Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month 01.16.1999 2:57 PM GLADYS M. ABRAMS 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not Institution, give street end number) 4c. County of Deeth MONTGOMERY SUBURBAN HOSPITAL BETHESDA If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min. 8. Dete of Birth 11.19.1913 9. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 1 M 2 F 85 Yrs. 577.14.7188 NY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits 1□ Yas 2□ No MARYLAND MONTGOMERY BETHESDA 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country?

Baltimore, Maryland 21215-0020 22 S44266 ABRANS, Gladys M. 1-16-99 257 PM. Division of Vital Records, P.O. Box 68760,

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Physician

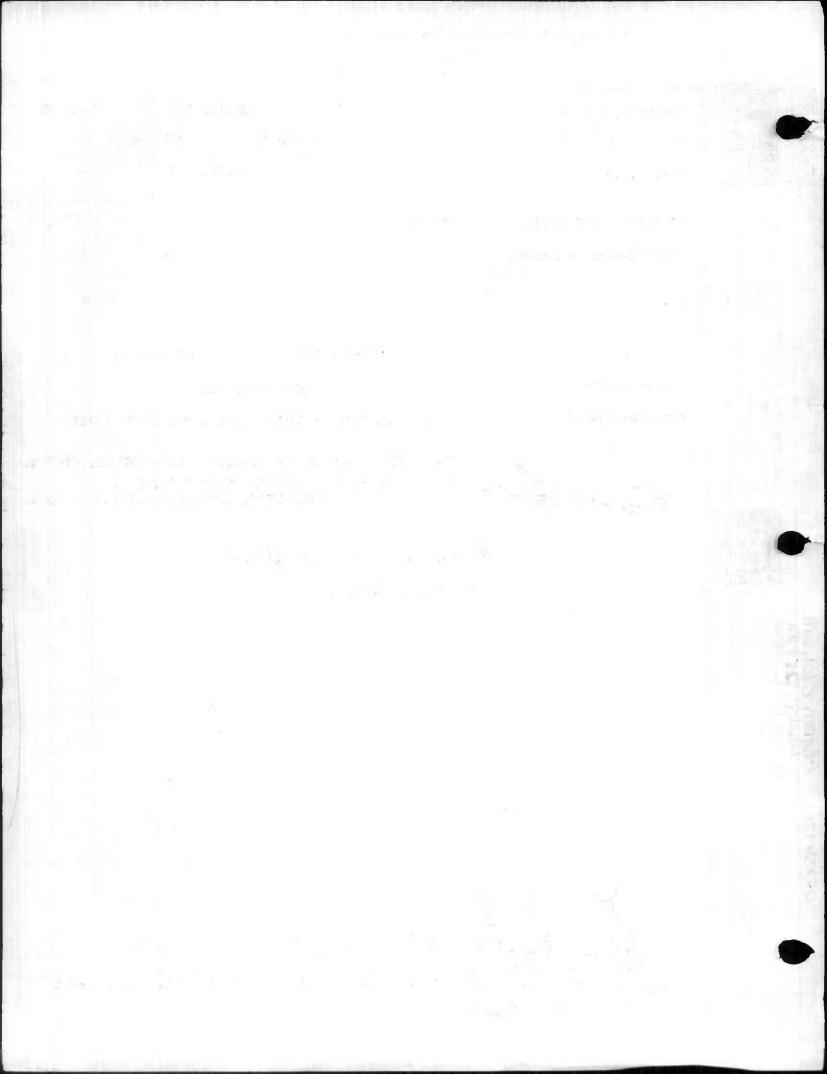
/Medical

Examiner

Funeral

Director

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(Special Elementery/Second 12		College (1-4or 5+)		TISTIC	during most of wo		COLUMN	CON TO	
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Pert II. Other signif	cant conditions co	ntributing to death but	not resulting in	the underly	ing cause giv	en in Pert I.	23b. Did	tobacco usa co		causa of death? y 4 1 Unknown
g /								20 NO	3 Frobabi	y 4 Onknow
							24e. Wes	s en eutopsy ormed?	evelleb	utopsy findings le prior to
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25. Wes case reference examiner?		Hospitel.			Oth	or.	eth (Check only		•	
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27. Menner of Deetl 1 Maturel 2 Accident 3 Suicide	5 Pending Investigation	Month, Day		njury M	28c. Injur Wor 1 🖂	k? Yes 2 □ No	200000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100T	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Pleca of Injury building, etc.	y - At home, fer (Specify)	rm, street, fe	ctory, office		28f. Location City or To	(Street end Numb wn, Stete)	per or Rural Ro	ute Number,
	Cartifulna Dh					no dot 1 -1	and die : "	anumate) :		
29a. Certifier (Check only one)	Medical Exami	nar: On the best of e and menner stete	xaminetion end ed.	for Investige	etion, in my o	pinion, deeth occ	e, end due to the urred et the time,	date end pleca,	end due to the	cause(s)
29b. Signature and	itie of certifier	1/		A	29c. Licens			29d. Date signe	-	
► /X	On 1	Dig/ra	MI)	0	3888	3	1/16/	99	
30. Name and ager	es of person moto	ompleted/dause of dea	ith (Item 23e) (Type, Print)	1	1.	1 ./	1 1	0	200:-
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Deborah L. Ake January 13, 1999 4a. Facility Nama (If not Institution, give streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Undar 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpiaca (State or Foreign Country) Months Days Hours 1□ M 200 F 41 578-84-0824 July 21, 1957 Virginia Usuat Rasidanca of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland | Montgomery Darnestown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 14505 Brookmead Drive 20874 United States 12. Was Decedent Ever in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritat Stetus 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No tf Yes, Giva Yaar or Dates: 1 ☐ Yas 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decadant's Education (Specify only highest grada complated) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Etemantary/Secondary (0-12) Collaga (1-4or 5+) Emergency Room Admissions Coordinator 5+ Hospital 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) James N. Ake Helen Hazard 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, State, Zip Coda) Barbara S. Hoffman/Cousin 5737 Windsong Ct., New Market, Maryland 21774 20b. Piace of Disposition (Nema of camatary, cramatory or other place) January 18, 1999 20a. Method of Disposition 20c. Location - City or Town, Stala 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 22 Name and Addrass of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funaral Service Licenses Bethesda-Chevy Chase, Inc., 7557 Wisc Avenue, Bethesda, Maryland 20814-3501 7557 Wisconsin M01126 23e. Part1. Enter the disaasa, or complications that caused tha daath. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximata tnterval Between Onset end Death Immediate Ceuse (Final disaase or condition rasulting in daath) * ASPIRATION PNEUMONIA Dua to (or as a consequence of): MALTIPLE SCLE ROSIS Dua to (or as a consequence of): Due to (or as e consequance of): Pert II. Other eignificant conditiona contributing to death but not rasuiting in the underlying cause given in Part t. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yee 2 ☑No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

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attending for use es

s been signed to should be deti

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Certification: To

Medical

To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

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Examiner must be notified at

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Maniel Hygiene.
Important: If item 27 is marked other than "natural" or the page.

Examiner Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or injury that initiated events rasulting in daath) Last Physician/Medicai þ Completed

24b. Wara autopsy findings evaitable prior to completion of cause of death? 24e. Wes an autopsy performed? ALL Vac OFFIAIR 4 C V- - 4 C V-

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5. Was casa rafarred to medicai	26. Piaca of Daath (C	Chack only ona)
axaminer? 1 ☐ Yes 2 No	Hospital: 1 ☐ Impatiant 26 ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa	5 ☐ Rasidance 6 ☐ Othar (Specify)
7. Mannar of Deeth 1 Maturat 5 ☐ Panding 2 ☐ Accidant invastigation	(Month, Day Yaar) Injury Work? M 1 ☐ Yes 2 ☐ No	d. Dascribe how injury occurred
3 ☐ Suicida 6 ☐ Couid not be 4 ☐ Homicide datarmined	28a. Place of injury - At homa, farm, streat, factory, office building, etc. (Specify)	Location (Straat and Number or Rural Routa Number, City or Town, State)

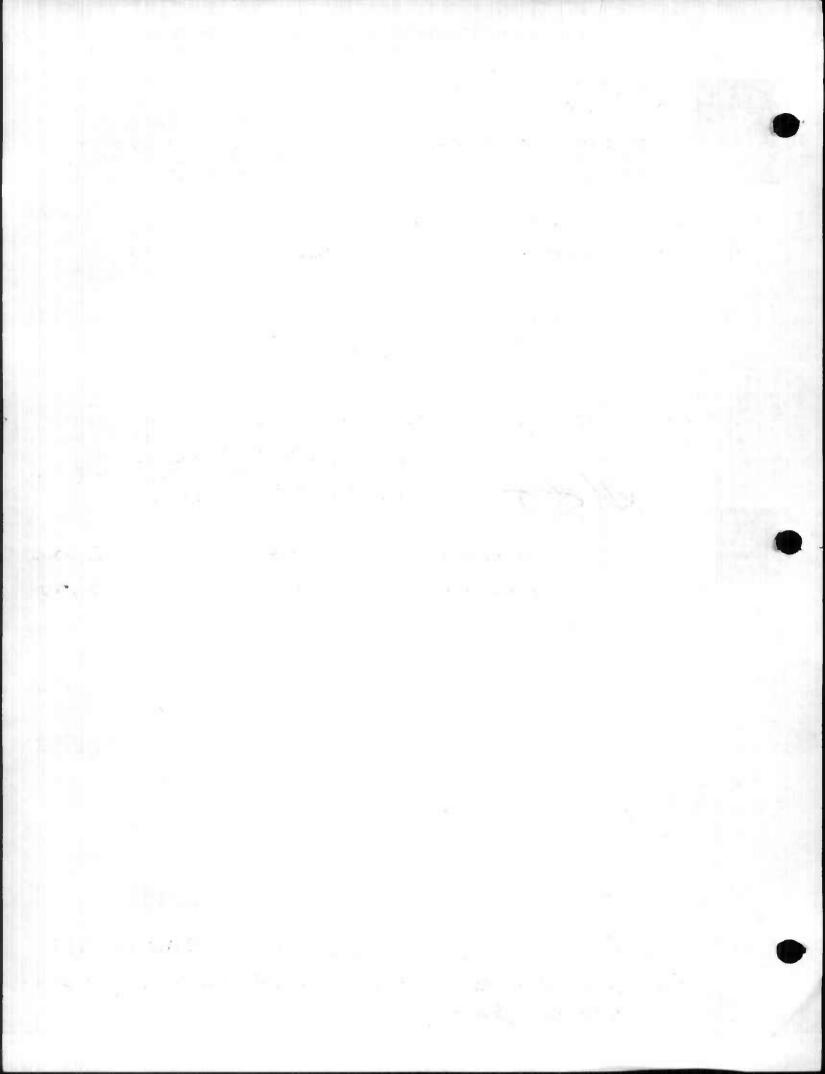
29a. Cartifiar (Check only one)	Certifying Physician 2 Medical Examinar:	an: To the best of my knowledge, daeth : On tha besis of examinetion and/or inv and mannar stated.	occurred at the time, date end place, en restigetion, in my opinion, deeth occurred	nd due to the ceuse(s) end menner as steted. d at the time, deta and place, and due to the causa(s
Office Committees of	state of outline		00-11	Tagina i am i a wa

complated cause of death (ttam 23a) (Type, Print)

no D26540 JAN 14 1999 (Itam 23a) (Type, Print) 16220 Frederick Rd Gaithers burg MD

State Registrar 31. Data filed (Month, Day, Year) JAN 1 9 1999

Schocher 167, Year) 32. Aggistrer's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\text{Q} \) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month ALEXANDER DARE IRGINIA 18, 1999 JANVARY 4a. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 1614 (BROOKE GROVE FOUNDATION) SANDY SPRING THE WOODS MONTGOMERY 7. Aga (In yrs. lest birthday) If Under 1 Yaar If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Sociel Sacurity Number Birthpleca (Stete or Foreign Country) 1□M 25F 578-12-2200 Yrs JUNE 16, 1913 N. CAROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD. MONTGOMERY SANDY SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1614 HICKORY KNOLL RD. 20860 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Wes Dacedant Ever in U,S. Armed Forces? 11. Merital Status Race - American Indian, Black, White, etc. 1 Never Marriad 2 Married 1 ☐ Yes 2 📉 No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 Divorced Yeer or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry Elementery/Secondary (0-12) College (1-4or 5+) 12 RET. - POSTAL WORKER U.S. POST OFFICE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) GEORGE NORWOOD MAMIE **JOHNS** 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) DR. A.J. ELLINGTON JR./NEPHEW 419 FOUNTAIN PL., BURLINGTON, N.C. 27215 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 1/19/99 RIVERDALE, MD. 21. Signature of Funeral Service Lice 22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P. A., SILVER SPRING, MD. ot enter tha mode of dying, such as cardiac or respiratory errest, approximate intervel Between Onset and Deeth rankrisio M00091 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) · VENTRIWLAR ARRHYTHMIA (SUDDEN CAR-MINUTSS DIAC Due to (or es a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated marks) Dua to (or as e consequenca of): thet initiated events resulting in deeth) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown HLZHEIMER'S DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yes 2 No 1 Tyes 2 No 25. Was case referred to medical

Physiclan /Medical Examiner

Physician

/Medical

Examiner

10e. State

Funeral

Director

28a-f show

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryle Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28s-1 show any injury or other traumatic event, the Medical Examinat must be not the at

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Maryland

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physician

Physician/Medical þ Completed Be 2

The law requires that the death certificete be executed for use es signed by the e has e 2 certificate had Hospital or Attending Physicien: '24 hours effer deeth. Funeral Director: Affer this certifica stely filled in by the funeral director, g Certification: 24 hours Medical

To the Hosp within 24 ho To the Fune completely f

Division of Vital Records, P.O. Box 68760,

State Registrar

29b. Signature and title of cartifier

5 Pending Investigation

6 Could not be determined

ATTENDING PHYSICIAN

28a. Dete of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28b. Time of

29c. License number D42046

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

26. Plece of Death (Check only one)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date and place, end due to the causa(s) and manner stated. 29d. Dete signed (Month, Dey, Year) JANUARY 18, 1999

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

GRACE BROOKE HUFFMAN, M.D. 18100 SLADESCHOOL ROAD SANDY SPRING, MARYLAND

Other: 4 Nursing Home 5 Residence 8 Other (Specify) FACILITY

28d. Describe how injury occurred

JAN 2 1 1999

1 Yes 2 No

27. Manner of Deeth

1 Natural

2 Accidant

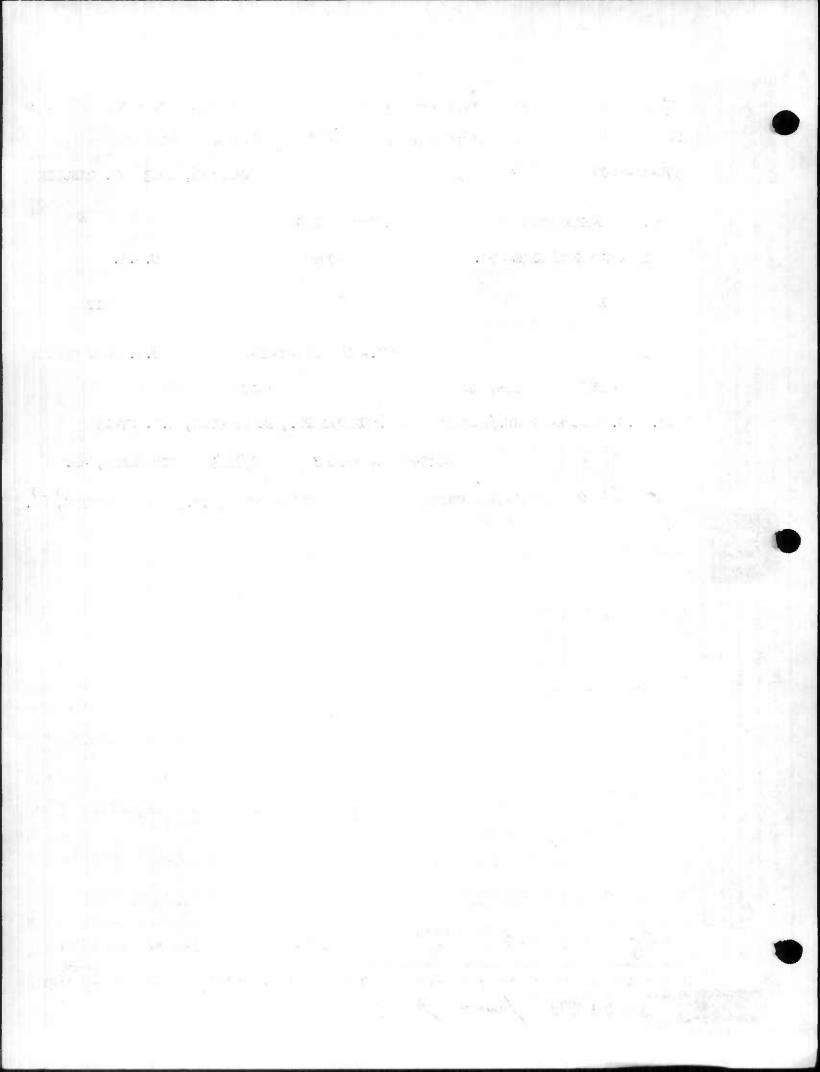
3 Suicide

29a. Cartifier

4 Homicide

(Check only one)

32 Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month 16, **Physician** Myrtle L. Astlin 1999 8:45P. Jan. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not Institution, give street end number) Examiner Layhill Genesis Elder Care Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Deys | Hours | Min. 8. Dete of Birth (Month, Dev. Year) Jan. 3, 1916 7. Aga (In yrs. lest birthday) 9. Birthpiece (Stete or Foreign **Funeral** 1 M XXF 83 Yrs. Maryland 578-42-6064 Director Usuel Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinational De nodred at Takoma Park Maryland Montgomery 1 Yes XX No Directo 10e. Street end Numbe 10f. Zip Code 20912 10g. Citizen of Whet Country? 6405 Eastern Avenue United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Dacedant of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Raca - American Indian 11. Marital Status Bleck, White, etc. 1 ☐ Yas XIX No If Yes, Give Yaer or Detes: 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: White Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede complated) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16h Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Meat Wrapper Safeway Food 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumema) Be William Harry Nicholson Nora Easton 19a. Informant's Name/Raletionship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rurel Route Number, City or Town, State, Zip Coda) Norma L. Coyner (daughter) 11709 Pine Street Beltsville, Maryland 20705 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 20e. Method of Disposition WBurial 2 ☐ Cremetion 3 ☐ Removel from State George Washington Cemetery 1/19/1999 Adelphi, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter tha disaase, or complications that caused the shock, or heert feilure. List only one cause on each line at caused the death. Do not antar tha moda of dying, such as cardiec or raspiratory arrest, Approximata Interval Between Onsat end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) DITA Examiner Examiner that the death certificate be executed physician end s the burief-trens Sequentially list conditions, if eny, leading to immadiate cause. Entar Underlying Ceuse (Diseese or Injury that Initiated events resulting in daath) Last Dua to (or es a consequance of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequanca of) Se esn signed by the a 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 20 No 3 Probably 4 Unknown P 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? Completed peen complation of cause of death? page 2 s certificate hes Hospital or Attanding Physician: director. 25. Was case referred to medical axeminar? Be 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 9 this funeral 27. Mannar of Deeth 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? Certification: 1 A Neturel 2 Accident 5 Pending 24 hours after death. 1 ☐ Yes 2 ☐ No investigation 3 Sulcida 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner as stated.

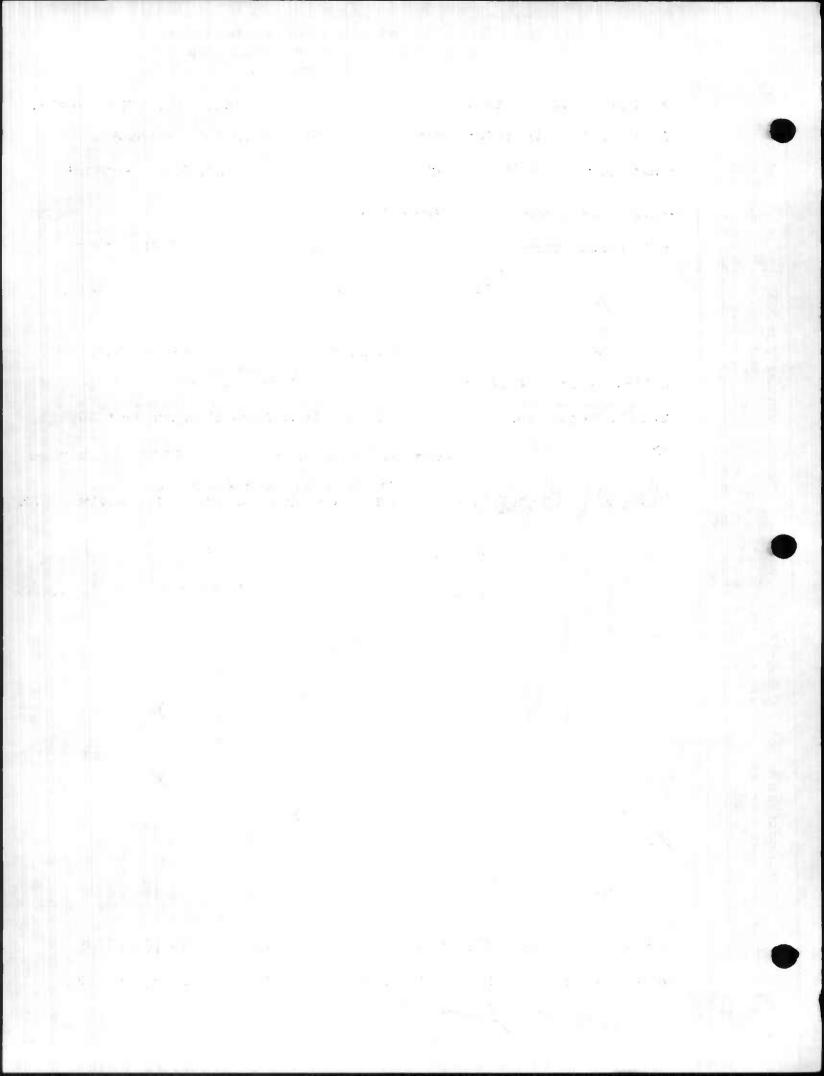
Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, data end place, and due to the causa(s) end menner steted. edical 29a. Certifier To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. Licansa number D38262 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Anurita Menhiratta, M.D. 18111 Prince Philip Dr., #212 Olney, Maryland 20832

State Registrar 31. Data filed (Month, Day, Yeer)

JAN 2 0 1999

32. Registrer's Signeture

Sporks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death Month Month Japanery 20 1900

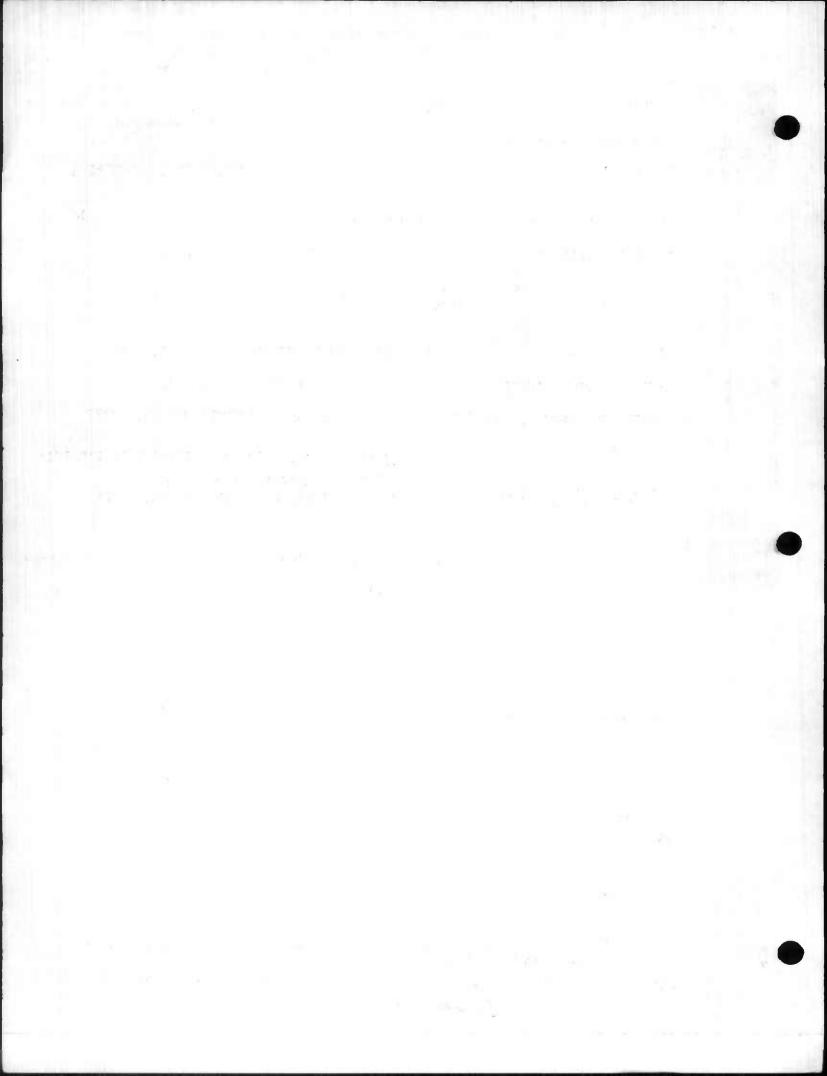
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	Funeral Director		5. Social Security Number 266 12 5614		ex OMM 2□F	7. Age (In yrs. 78	lest birthdey) Yrs.	Months Days			igh 1920	9. Birthplec	e (Stete or Foreign
	and a		Usual Residence of Deced			10c. Ci	ty, Town or Lo	ocation				10d.	Inside City Limits
	the Maryland 28s-f show hottfled at	tor	MD.	10NTG0	MFRY		GAITHE	RSBURG					1 Yes 2 No
	or 28)irec	10e. Street end Number					10f. Zip Code			10g. Citizen of	Whet Country	?
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21215-0020	rurs after death with the Maryla ref., or thems 23s or 28s-f show Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 XDiv		12. Was Deced Armed For 1 Yes : If Yes, Give Year or Da	ces? 2□No193	9-	Was Decedent of If Yes, specify Cui 1 ☐ Yes 2 No	Hispanic Orlgin? (S ban, Mexicen, Puer Specify:	Specify Yes or N to Rican, etc.)		ce-American ck, White, etc	
5-0	natural, "natural", edical Exp	Completed	15. De	cedent's Ed	ucetion de completed)		16a. Dece	dent's Usuel Occu	ipation a during most of wo	rkina	16b. Kind of B	usiness/Indus	try
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1000	20 年 年 是		19a. informant's Name/Rei			IGHTER	19b. Maili 48 HA	ng Address (Stree ARMONY HA	LL ROAD,	GAITHERS	BURG, MD	, State, Zip Co . 2087	7 7
Baltimore,	If the It is not on other or other		20a. Method of Disposition 1 Dauriel 2 Crem			toto	cemetery, cre	metory or other pla		Date	20c. Location		
量	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Ot 21. Signature of Funeral Se		·	IME		ITAN CRE		1/22/99		DKIA, V.	IRGINIA
Ba	permit. Departm Importa any inju		1 mari			her			rs Barber 5038, LA			20882	
	Physician		23a. Pert1. Enter the disea shock, or heart failure									Ar	pproximate terval Between nset end Deeth
7	/Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)		Θ				ailure	2			2 days
L		ē			(O Due to (oras a conse	quence (L)					day:
	cuted	Examiner	Sequentially list conditions	C	b. ———	Due to (c	or as a conse	quence of):					- Coar
90,	e exe	EX	Sequentially list conditions if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· J	•							i	
68760,	icete be executed physician end s the burial-transit	edicai	that initiated events resulting In death) Last)	C	Due to (d	or as a consec	quence of):					
Box 6	n certific anding p	2			d								
	ne death ce the attendi	Physician/	Part II. Other significent co	nditions co	ntributing to dea	ath but not res	sulting In the u	inderlying ceuse g	iven in Part I.	23b. Dic	i tobecco ues co	ontributa to th	e cause of death
, P.O.	# 5 e	by Phy	Alzhein	ver:	SDe	men	tra			1□	Yes 2 No	3 Probab	oly 4 Unknow
Records,	- LD 69	Completed t								24a. Wa	s an eutopsy formed?	avalla	autopsy findings ble prior to letion of ceuse ath?
	0 - 0	Com								1	Yes 200	1 🗆 Y	es 2□No
of Vital		Be (25. Was cese referred to me						26. Place of De	ath (Check only	one)		
of	\$ 00	10 10	1 □ Yes 2 No				ER/Outpatie	nt 3LI DOA		1	sidence 8 DOt		
no	ding Phy h. After thi funeral	tion		ending	28e. Date of (Month)	n, Day Year)	28b. Time o Injury	W	ork? ☐ Yes 2 No	28d. Describe	how Injury occu	rred	
Division	or Attending I after deeth. Director: After	Certification:	3 Suicide 6 □ 0	could not be etermined	28e. Plece o	of Injury - At h g, etc. (Specil	ome, farm, str fy)	reet, factory, office	•		(Street end Num own, Stete)	ber or Rurel R	oute Number,
_	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai Ce	29a. Certifier 1 Ca (Check only one)	rtifying Phy dicat Exam	iner: On the bas	sis of examina	wledge, deat ation end/or in	h occurred at the t vestigation, in my	ime, date end plec opinion, death occ	e, end due to the urred et the time	e cause(s) and m	anner as state and due to the	ed. e cause(s)
	vithin o the	Mec	29b. Signature and titig of o	ertifier	end manne	ા કાશાસવા.		29c. Licer	se number		29d. Dete signe	ed (Month, Day	y, Year)
	6+1		· By	13	Falue	exa	m		22019		Januar	y 21,	1999
			30. Name and address do						Frederick	. Marvl	and 2170)2	

State Registrar 31. Date filed (Month, Dey, Year)

JAN 2 2 1999

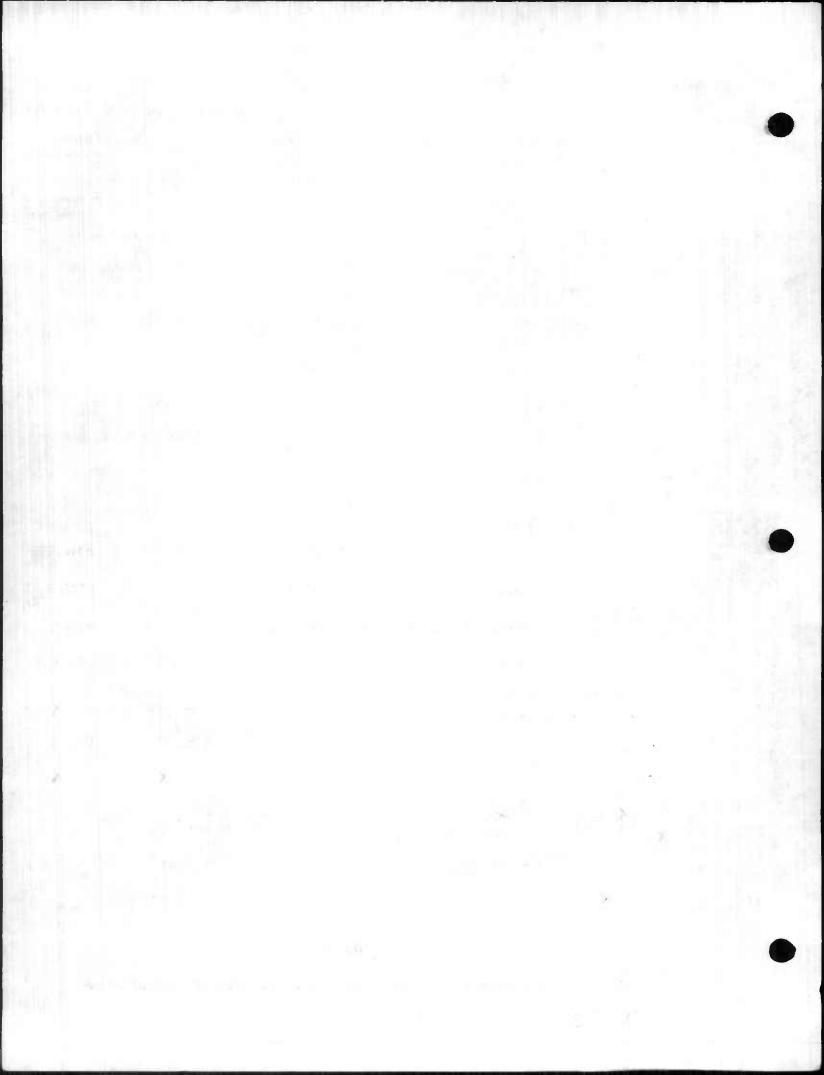
32. Registrer's Signature

B. Sports



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

			Cei	tificate of	Death		Reg. No.		•
cian	1. Decedent's Name (First, Middle, Las Albert Guy					2. Date of De Month	Day	Year	ima of Death
dical	4a Facility Name (If not institution, give				4b City Town	JANUA or Location of Deat	RY 18, 1		19 AM
iner	Saint Joseph		enter		Tow			Baltimo	ore
ıl	5. Social Security Number 6. S	ex 7. Age (II	n yrs. last birthday)	If Under 1 Year	If Under 24 H	Irs. A Date of Bir	th		State or Foreign
	217 07 1241	RM 2□F	83 Yrs.	Months Days	Hours M	Dec 3.	1915	Maryla	
	Usual Residence of Decedent 10a. State 10b. County	110	Oc. City, Town or Lo	cation					side City Limits
5	Maryland Balti		oc. Only, Town or Eo	Cation	Upperc	·O			Yas 2 No
	10e. Street and Number	nore		10f. Zip Code	opporo		10g. Citizen of V	What Country?	
	16741 Gorsuch Mil	1 Road			2115	5		SA	
	11. Marital Status	12. Was Decedent Eve	r in U,S. 13.)	Was Decedent of	Hispanic Origin?	(Specify Yes or No		e - American Ind	lian,
	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cub □ Yes 25\No		erto Hican, etc.)	Specify	ck, White, etc. White	е
ŀ	15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usuel Occu	pation	endring.	16b. Kind of Bu	usiness/Industry	
ŀ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done OO NOT use retire	d)	vorkary	Acoba	14 Davis	~~
ŀ	8			Foreman	T 40 14-11-4-1	1 187 18.4.4	-	lt Pavi	119
	17. Father's Name (First, Middle, Last) William G. Ashe					Name (First, Middle L. Bosle		10)	
	19a. Informant's Name/Reletionship (7	Type Printl	19h Mailir	n Aridraes (Strae		Rural Route Numb		State Zin Code	1
	Donna Thompson, d					Parkton, I			,
	20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other pla	anl .	Date	20c. Location -	City or Town, SI	lata
l	1 Surial 2 Cremation 3 4 Donation 5 Other (Specify			nel Ceme		1/21	Parkto	n, Md	
	21. Signature of Funeral Service Licen			. Name and Addre		Eline Fu			
	Ateurs 1	UTPU	0	934 Sout	th Main	St, Hamps			
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	death. Do not ente					Appre	oximate /el Between
	shock, or heart failure. List only t	one cause on each inte.						Onse	t and Death
	Immediate Causa (Final disease or condition	VENTRIC	ULAR FIE	BRILLAT	ION			MI	NUTES
l	resulting in death)	Due	e to (or as a conseq	uence of):				-	
ı		. ACUTE M	YOCARDIA	AL INFA	RCTION			HC	URS
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	e to (or as e conseq	uence of):					
l	Cause. Enter Underlying Cause (Disease or injury that initiated events	c CORONAR			SE			YE	ARS
ı	resulting in death) Last	Due	to (or as a conseq	uence or):					
ĺ		d. RESPIRA	TORY FA	ILURE				HC	JURS
	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	nderlying cause gi	ven in Part I.	23b. Did	tobacco use co	ntribute to the c	ause of death?
	COMPLETE HEART	BI OCK				10	Yes 2 No	3 Probably	4 Munknow
	COM DETE MEAKI	BLOOK							
	DIABETES						an autopsy ormed?	24b. Wera au available	topsy tindings prior to on of cause
						-	1.	of death	?
	HYPERTENSION		27.24.14			10	Yes 2NNo	1 ☐ Yes	280No
	25. Was case referred to medical axaminer?	Hospital:		_ 0	hor	Deeth (Check only			
	1 ☐ Yes 2,2 No 27. Manner of Death	28a. Dete of Injury	2 ER/Outpatien	1 3LI DON	4 CHOISH	g Home 5 Res	dence 6 Oth how injury occur		
	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ser) Injury	Wo	rk?]Yes 2 □ No	200. 2000/20	now anjury occur	.00	
	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, str	eet, factory, office			Street and Numb	per or Rural Roul	te Number,
	4 Homicide	building, etc. (S	эр еспу)			City or To	wn, State)		
ŀ	29a. Certifier 12 Certifying Phy (Check only 2 Medical Exam	reician: To the best of m	y knowledge, death	occurred at the ti	me, date and pla	ace, and due to the	cause(s) and me	enner as stated.	Supp.(s)
	one) 2 Medical Exam	iner: On the basis of ext and manner stated	sitimetion and/or inv	restigation, in my	openion, death or	ccurred at the time,	uate and place,	and due to the c	aUS8(S)
	29b. Signature and title of certifier	1 () I'M				29d. Date signe		(ear)
	1 Kickerd L	- Lutt	noun	_ D318	26		1-18	3-77	
	30. Name and address of person who o	•							
j	RICHARD L. LINT			YORK R	DAD, T	OWSON, M	ARYLANI	21204	-
	31. Date filed (Month, Day, Year)	32. Registrar's	o-gnature						



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Desth 2. Dete of Death 1. Decedent'a Name (First, Middle, Last) Day 4b. City, Town, or Location of Deeth 4c. County of Death CARL R ANGERMAN 20 25 4a Facility Name (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Devs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 10M 20 F Deys Hours 51 Yrs. 221 36 1753 October 11,1947 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico 1X Yes 2 □ No Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 North Main St 21830 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Microbiologist State of Maryland 12 4+ 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) Albert Angerman Naomi Lebegern 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Patricia F. Angerman/Wife P.O. Box 194, Hebron, MD 21830 20b. Piece of Disposition (Name of cemetery, crematory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 1/17/99 Hebron, MD 4 Donetion 5 Other (Specify) Springhill Memory Gardens 21. Signature of Funeral Service Lie 22. Name and Address of Facility Holloway Funeral Home Professional Association Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediete Ceuse (Final disease or condition resulting in death) 30 mer " Cardiac arrest probably ten hypotensia Duelo (or as a consequence ol): ractory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Acuamous cell caranone of base of tongue with 24b. Were autopsy findings evailable prior to 24a. Was an eutopsy performed? neck nodal metastasis. Pt had entrapperates cardiai completion of cause of death? 1/12/98 was resunitated and rearrested in ICU 1 Yes 2 No 1 ☐ Yes 2 ☐ No arrest 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatlen1 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide

certificate be executed physician end the burial-trans Box 68760 80 esn 0 signed by the Division of Vital funeral director, this After t or Attending Peter death. To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the

Physician/Medical P Completed Be

Medical

4 Homicide

29b. Signature and title of certifier

29e. Certifier (Check only one)

Examiner Certification:

Physician

/Medical

Examiner

Director

Funeral

à

Completed

2

Funeral

Director

item 27 is marked other than "naturel", or items 23e or 28a-f show other traumatic event, the Modical Examinar must be notified at

the Merylend

with

should be filed within and Mental Hydiene. Hygiene.

is marked

permit. Pages 1 end 2 st Department of Health and Important: If Item 27 Is n

any injury or

Physician /Medical

Examiner

altimore,

A non man

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D40516

SALISBURY

MD

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and manner es stated.

29d. Date signed (Month, Day, Year) 99 21:15

281. Location (Street and Number or Rural Route Number, City or Town, State)

21804

MICHAEL J. KELLGHER MD 106 MILFORD ST

31. Dete filed (Month, Day, Year) JAN 1 9 1999

32. Registrer's Signature

28e. Place of Injury - At home, lerm, street, factory, office building, etc. (Specify)

JAN 18 22 / Lane of officer

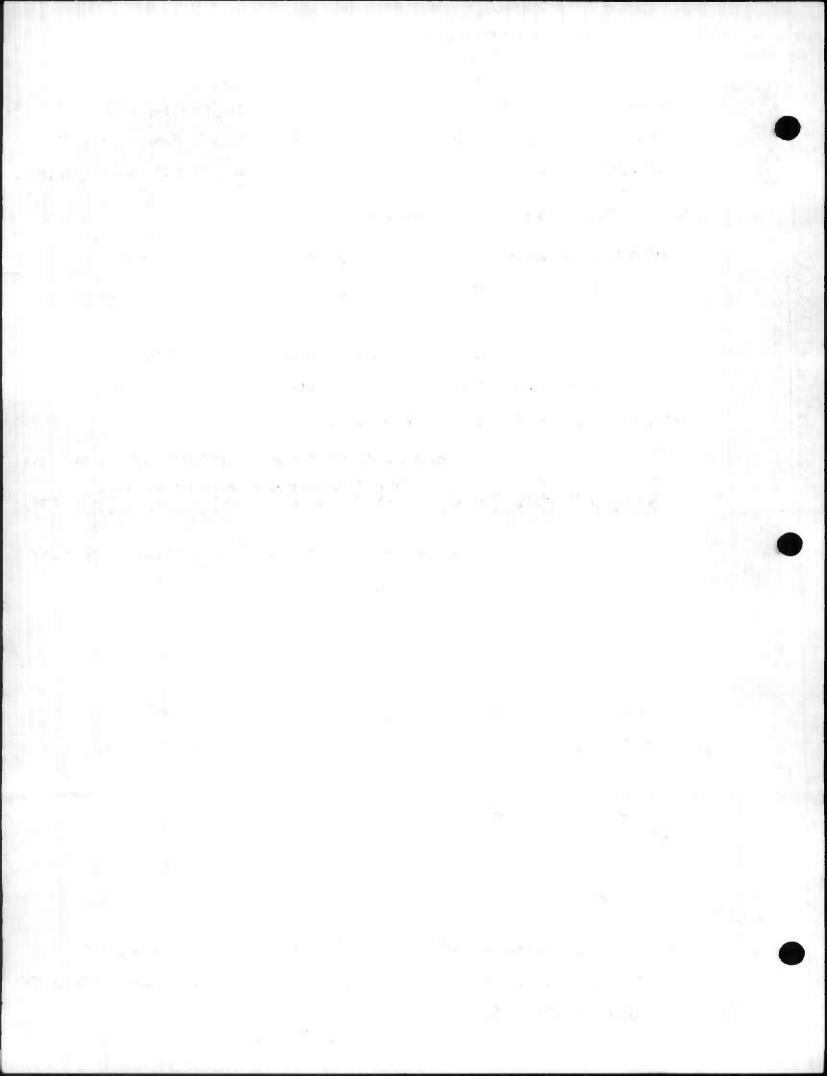
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State of Maryland / Department of Health and Mental Hygiene

02508

					,	Certificate of		Rec	, No.	UZ	000
	Dhue	iolon	1. Decedeni's Name (First, Middle, La					2. Date of Death Month	Day	Year 3	3. Time of Death
	Phys /Me	ician dical	Norman Burrett	Blackwoo	d, Jr.			JANUAR	18	1999	10:45 AI
	Exam		4a. Facility Name (If not Institution, giv Doctor's Commun		al		4b. City, Town, or L Lanham			of Death Ce Geoi	rge's
	Funera Directo			ex 7. Age ¶ M 2□ F	(In yrs. last birt	Months David		8. Dele of Birth (Month, Day,) May 20,	T928	Country)	a (State or Foreign ngton, D.C
9-1-1	B		Usual Residence of Decedent 10e. State 10b. County		10c. City, Town	or Location				104	Inside City Limits
	the Maryla r 28a-f show notified at	Director	Maryland Prince G			ville					1 ☐ Yes ¾∭(No
0	ath with the 23a or 2	rai Dire	11701 Caverly A	venue			705			What Country?	
300	020 ours after do nal', or items Examiner or	by Funeral	11. Maritai Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedeni Ev Armed Forces? 1 ☐ Yes 2020No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes ♣CXNo		ecify Yes or No- Rican, etc.)		ca - American I ck, White, etc. v: Whit	
ACKL	21215-0020 d within 72 hours at glene, ir than "natural", or the Medical Exam	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's Usual Occu (Give kind of work don- life. DO NOT use retir	e during most of work	ing 16	6b. Kind of Bi	usiness/Indust	iry
5	d 21; filled will Hygiene ther the	E O	Elementary/Secondery (0-12)	Coilege (1-4or 5+)	Re	lay Test S	pecialist		PEPCO		
3	Maryland 2 should be filled 2 should be filled by and Mental Hygy 7 is marked other traumetic event, 1	To Be	17. Felher's Neme (First, Middle, Last) Norman B. Bla	ckwood, Sr	•		18. Mother's Nam	e (First, Middle, Ma	iden Sumam	White	
THAT			19a. Informant's Name/Relationship (Betty Lou Blackwo			Mailing Address (Streets as #1		el Route Number, (City or Town,	State, Zip Co.	de)
TORINA	Ores t		20a. Method of Disposition 120 Burial 2 Cremation 3 4 Donation 5 Other (Specific		cameter	Disposition (Name of c, crematory or other pl Washingto				City or Town,	
4	altim mit. Pa partmen portant: y injury	6	21. Signature of Funeral Service Licen				ress of Facility Borgward				raryrand
(8)	M REPLAN		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the	old . ne death. Do n	4400 Powd	er Mill Ro	1. Beltsv	ille,	Maryla	and 20705
	Physician	_								On	nset and Deeth
	/Medica Examine		Immediele Ceuse (Final disease or condition resulting in deeth)	a. Me	test	cetic C	olon le	escin	oura		nes
		ě		D	ue to (or as a c	onsequence of):					
	cuted	Examiner	Sequentially list conditions,	b	ue to (or as a c	onsequence of):				1	
	death cardificate be executed cettending physician and defor use as the buriel-transit		Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or Injury	C						į Į	
	68760, ifficete be ext g physician as the buriel	edicai	that initiated events resulting in death) Lasi	Du	ue to (or as a co	onsequence of):				1	
	Box 6 eath certif	Physician/M		d							
	O. B s deat	Sicis	Pert il. Other significant conditions co	ontributing to death but	not resulting in	the underlying cause g	iven in Part I.	23b. Did tob	acco use co	ntribute to the	e cause of death?
	P.O. het the od by the detecher		anterious	esotic U	redic	ovas cul	er	1 🗆 Yes	20 No	3 Probabi	ly 4 Unknown
	Division of Vital Records, P.O. or attending Physician: The law requires that the defer death. Director: After this certificate has been signed by the to it by the funeral director, page 2 should be deteched in by the funeral director, page 2 should be deteched.	eted by	D. seure					24e. Was an performe	autopsy ed?	availet	autopsy findings ble prior to letion of cause
	Rec The law	Completed								of dee	oth?
	of Vital Re-		25. Was case referred to medical				20 Place of Deat		2 400	1 □ Y€	es 21 No
	of Vita Physician: this certificant	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 □ ER/Out	patient 3 DOA	thor	h <i>(Check only one)</i> me 5 ☐ Residen		er (Specify)	
	On O ding Ph h. After thi funeral		27. Manne of Deeth 1 ☑ Naturai 5 ☐ Pending	28a. Date of Injury (Month, Day)				28d. Describe how			
	VISION Attending or death. ector: After	cati	2 Accident investigation			M 1[Yes 2□No				
	Divi	Certification:	4 Homicide determined	building, etc.	(Specify)	n, street, fectory, office	10	28f. Location (Stre City or Town,		er or Hurai Ho	oute Number,
	Division To the Hospital or Attending is within 24 hours after deader. To the Funeral Director: After completely filled in by the funeral	edicai	29a. Certifier (Check only one)	elclan: To the best of a lner: On the basis of ea and menner state	xeminetion end	deeth occurred at the to for investigation, in my	time, date end plece, opinion, death occur	end due to the cau red at the time, dete	se(s) end ma e and plece,	anner es state end due to the	d. cause(s)
	Tot Common	W	29b. Signature and title of certifier	eaute .	ALD .		17572			d (Month, Day	
			30. Name and address of person who of	completed cause of dea		vpe. Print)	nterwa				
	S	tate	31. Date filed (Month, Day, Year)	32. Registrer	Signature			1	000	Cirion	20.
	Regis	-	JAN 2 0 199	9 Sener	me for	G. Spore	2				



Physician /Medical Examiner

Elizabeth Boteler 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Sacred Heart Home Hyattsville If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Feb. 12, 1918 **Funeral** Days Months Hours 1 M XXF 577-12-7486 80 Yrs. Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director Anne Arundel 288-6 Maryland Odenton 10e. Street and Number 10f. Zip Code b 697 Lions Gate Lane 21113 flams 23s Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ②CNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Merried "natural", or f Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: py XXWidowed 4 □ Divorced should be filed within 72 hou and Mental Hygiene, a marked other than "nature sumatic event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Administrator parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If then 27 is marked offly any injury or other traumetic event 17. Father's Neme (First, Middle, Last) Be Ashby Campbell Carrie 19e. Informent's Neme/Relationship (Type, Print) Patrick T. McNaughton (nephew) same as #10 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) XX Burial 2 Cremation 3 Removel from Stete Fort Lincoln Cemetery 1/19/1999 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, of compliments that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel Meumonia disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner Spiratum or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): pur disease Box 68760. physician s the buria ackinsons Physician/Medical Due to (or as a consequence of): for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Senile dementia þ Completed 24a. Wes an autopsy performed? page 2 1 ☐ Yes 2XXXIII certificate Division of Vital 25. Wes case referred to finedical examiner? Be 26. Place of Deeth (Check only one) 1 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28h. Time of 28c. Injury at Work? 5 Pending investigation After Naturel after deeth.

Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 4 Homicide Hospital 24 hours a Funeral D 29a. Certifier edicai (Check only one)/ within 2 94 29c. License number 2 022780 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Peter Schissler, M.D. 7500 Greenway Center Dr., #430 Greenbelt, Maryland 20770

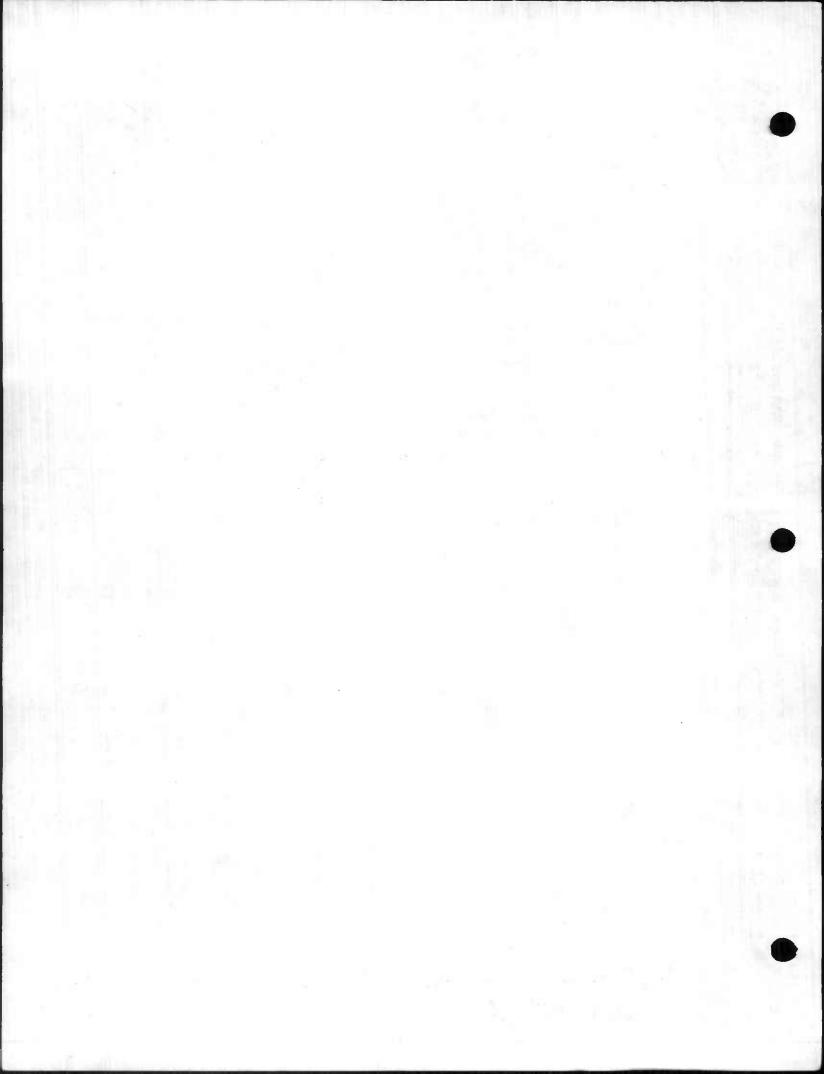
1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dey Month January 14,1999 7:30P.M. 4c. County of Death Prince George's 9. Birthplace (State or Foreign Virginia t Od. Inside City Limits 1 Yes XXNo 10g. Citizen of Whet Country? United States 14. Race - American Indian, Bleck, White, etc. White Specify: 16b. Kind of Business/Industry U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20c. Location - City or Town, Stete Brentwood, Maryland 22. Name and Address of Fecility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 Approximate Interval Between Onset end Deeth weeks 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 Yes XX No Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner steted. 29d. Dete signed (Month, Day, Year) January 15, 1999

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) JAN 20 1999

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Barbara Lee Bouman January 13, 1999 2:45 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town. or Location of Death 4c. County of Deeth Examiner Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Months Days Hours 1□ M 250 F 51 Yrs. Director 213-46-0891 Maryland Feb. 23, 1947 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits ahos the Manda than "natural", or items 23s or 25s-f shor the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3 Old Coach Court 20854 United States
14. Race - American Indian, Funeral 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à Yeer or Dates: 1969-1973 White 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fi Department of Health and Mantal H Important: If them 27 is marked off any Injury or other traumatic even Be 2 should be fl and Mental F Albert John Stapf Mary Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Lawrence J. Bouman/Ex-Husband 7428 Old Maple Square, McLean, Virginia 22102 20b. Place of Disposition (Name of cemetery, cremetory or other place) an. 17, 1999 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Panorama Memorial Gardens Strasburg, Virginia Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Respiratory Failure 24 hours Examiner Due to (or as a consequence of): Cerebral Bleed 1 week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hydrocephalus 3 days Physician/Medical ŧ Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 6 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy completion of cause of death? Dage 2 certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 뿛 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Affec 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident or Attend after death Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a, Certifier Medical end menner steted. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) Wy 10+1 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Kevin Crutchfield, M.D. 31. Date filed (Month, Dey, Year) 32 Registrar's Signature State JAN 19 1999 Registrar

DHMH 16 Rav 6/95

Souman

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

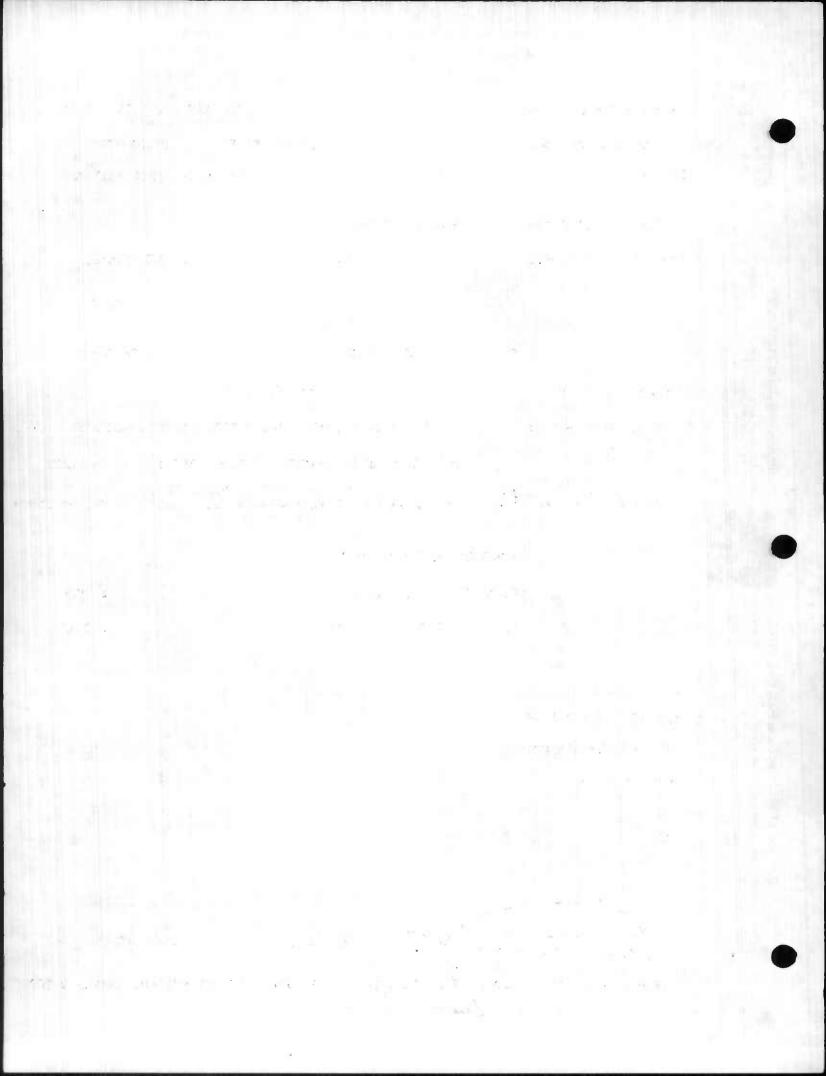
State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** JANUARY 19, 1999 4:09 P.M. CHARLES DONALD BOYER /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 12905 BUCCANEER ROAD SILVER SPRING

If Under 24 Hrs. 8. Date MONTGOMERY If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days MXM 2DF Months Hours Min Yrs. 54 Director 213-44-3920 APRIL 22, 1944 MARYLAND Usuel Residence of Decedent with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND | MONTGOMERY SILVER SPRING 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number Frankher must be r 12905 BUCCANEER ROAD 20904 UNITED STATES

14. Race - American Indian, death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ◯XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) se filed within 7 al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTANT D.C. GOVERNMENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth any Hijury or other traumatic event ans. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RICHARD E. SMITH BESSYE HOUGH 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN W. BOYER - WIFE 12905 BUCCANEER ROAD, SILVER SPRING, MARYLAND 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 【Cremetion 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) FORT LINCOLN CREMATORY 1-21-99 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical mediate Cause (Final ISCHEMIC CARDIOMYOPATHY disease or condition resulting in death) 1 YEAR Due to (or as a consequence of): Examine CORONARY ARTERY DISEASE YEAR Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and-Due to (or as a consequence of) physician a the burial-Box 68760. LEFT VENTRICULAR ANEURYSM 1 YEAR 8 Physician/Medical that initiated events resulting in death) Last 1 995 2 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ž signed by t 1 Yes 2 No 3 Probably \$ Unknown Division of Vital Records, P. CAROTID ARTERY DISEASE py 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peeu LEFT BUNDLE BRANCH BLOCK completion of cause of death? H. frector, page 2 a Ž 1 Yes 2 No 1 □ Yes 2 No HYPERLIPIDISM Physician: 88 25. Was case referred to medical examiner? 26. Place of Death (Check only one) XXYes 2 No Other: 4□ Nursing Home XX Residence 6 □Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 書 funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: Atte Attending **∂CO**4atural 5 Pending 1□Yes 2□No investigation or Attend after death Director: 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide A 24 hours of the Funeral Dis-Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated,

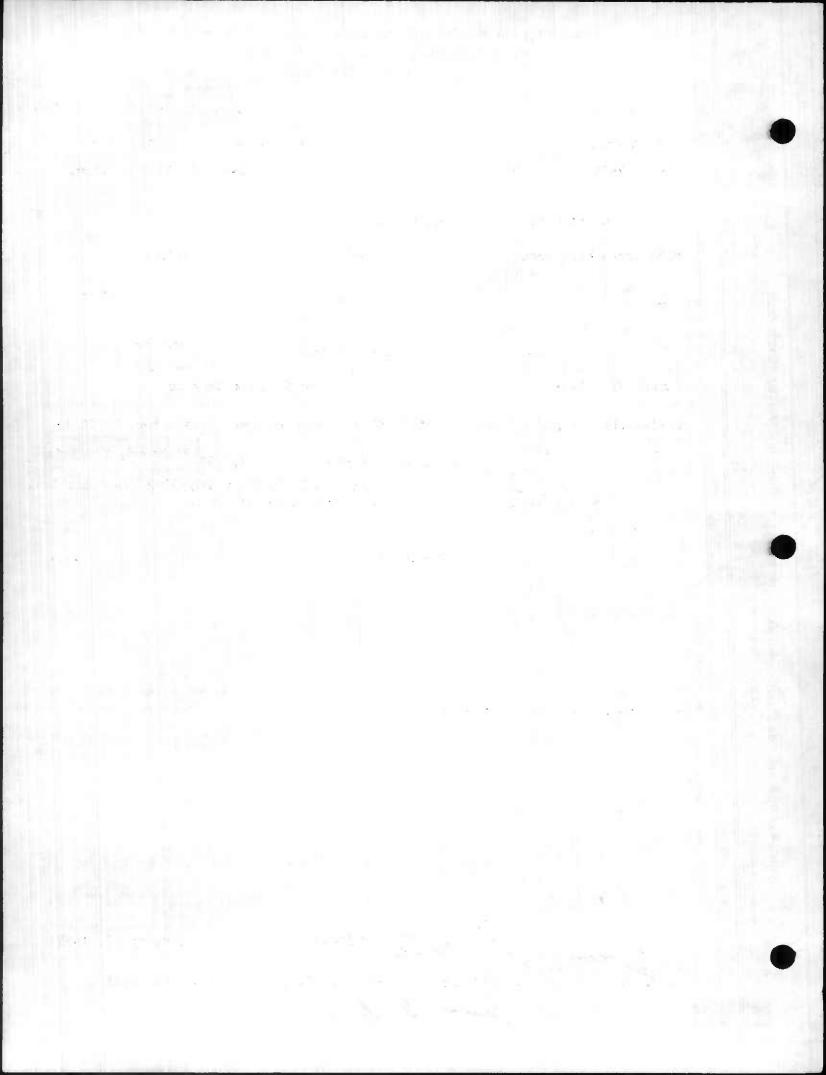
Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the To the onw 29b. Signatine and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of dealty (Item 23e) (Type, Print) DAVID H. GROSSBERG, M.D., 10313 GEORGIA AVENUE, #308, SILVER SPRING, MARYLAND 20902 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State JAN 22 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 5

ian	1. Decedent's Name	(First, Middle, Las	et)						2. Dete of Dee Month	th Dey	Yaar 3.	. Time of Deeth
ical	Sarah J.								Jan. 16			5:20AM
ner	4e Facility Name (If		street end nun	nber)			4	4b. City, Town, or 1		4c. County		
	Manor Ca			7 4 "	to a trace and	If I lado	r 1 Yaar	Chevy Ch	lase	Montg	gomery	100-1 Fi
	5. Social Security Nu 579-62-74	04 1	BX □M 2⊠ F	7. Age (In yrs. 88	Yrs.	Months		Hours Min.	8. Dete of Birth (Month, Dev Dec • 20	Year) 1910	Country) Maryla	o (Stete or Foreign and
	Usuel Residence of I	Decedent 10b. County		10c. Cit	y, Town or Lo	cation			3		10d.	Inside City Limits
tor	MD	Montgome	ry	Chev	y Chas	e						1 ☐ Yas 2 ☐No
Director	10e. Street end Num	ber					Code			0g. Citizen of V	Whel Country?	
	8700 Jone	s Mill R	oad			208				U.S.A.		
	11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed 4		12. Was Dece Armed For 1 Tyes If Yes, Giv Year or De	2 ⊠ No a				lispanic Origin? (S an, Mexican, Puert Specity:	pecify Yas or No- o Rican, atc.)		a - Americen I ck, White, etc.	
	(Specif	15. Decedent's Ed y only highest gra	de completed)		16e. Deced (Give	lent's Usu kind of wo DO NOT u	el Occup ork done isa retired	ation during most of world)	rking	16b. Kind of Br		ry
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	Samuel Ki							Sarah El				
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	Christoph 20e. Mathod of Dispo		s S	on 20b. F	Plece of Dispo	sition (Ne	me of	ase Park	way, Was	hington 20c. Location -		
	1 ⊠ Buriel 2 □	Cremetion 3 ⊠ i □Other (Specif)		Steta	emetery, crem				1/22/99	Richmon	d, Vir	ginia
	21. Signeture of Fun	eral Sarvice Licen	600					ss of Fecility awler's S nington,			Viscons	in Ave.
	23a. Part . Enter the	di se or comp	olications thet cannot cause on e	aused the deet							Ap	proximate ervai Between
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	immediete Ceuse (F disease or condition	inel		Pr	neumoni	a					1	week
_	resulting in death)			Due to (or es e conseq	uence of	:					
Examiner		•	b									
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	that initieled events		c	Due to (n	er es e conseq	uenca of						
MICHICAL	resulting in deeth) Le	est	d	200 10 (0	50 0 5011664	231.04 01)						
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III SICIALINI	Part II. Other signific				ulting in the ur	nderlying	causa giv	van in Part I.				e cause of death
	Arteriosc	Lerotic	Heart D	isease					101	fes 2 No	3 ☐ Probab	ly 4 □ Unknow
									24a. Was perfo	an autopsy med?	evailel	autopsy findings ble prior to letion of cause oth?
									101	es 25€No	1 □ Y	es 2 No
	25. Wes cese referre	ed to medical						28. Place of De	eth (Check only o	ne)		
2	1 ☐ Yes 2 ◯XN	lo			ER/Outpatien			4AAJ Nursing F	fome 5 ☐ Resid			
cel micanoni	27. Menner of Deeth 1 ☒ Naturel 2 ☐ Accident	5 Pending investigation		of injury h, Dey Year)	28b. Time of Injury	М	28c. Injui Wod 1 □	ryet rk? ∣Yes 2 □ No	28d. Describe I	ow Injury occur	rred	
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		of Injury - At h	ome, ferm, str	eet, fecto	ry, office		28f. Location (S City or Tox	Street end Numi m, Stete)	ber or Rurel R	oute Number,
	29a, Certifier (Check only one)	Certifying Phy ☐ Medical Exam	vsician: To the inner: On the ba	sis of examina	wiedge, deeth	occurred vestigetion	et the tinn, in my c	me, date end plece ppinlon, deeth occu	e, end due to the curred et the time,	ceuse(s) and made and plece,	anner es state end due to the	ed. e ceuse(s)
7	29b. Signature and p	sierol cegitier		5/	-	29	c. Licans	sa number		29d. Date signe	ed (Month, Day	y, Year)
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	1/	me	//	10	ak e		0041	13		Januar	y 20,	1777
Medical	30. Neme and address	Ama ss of person who	completed ceus	e of death (Iter	n 23e) (Tyne		0041			Januar	y 20, 1	1999



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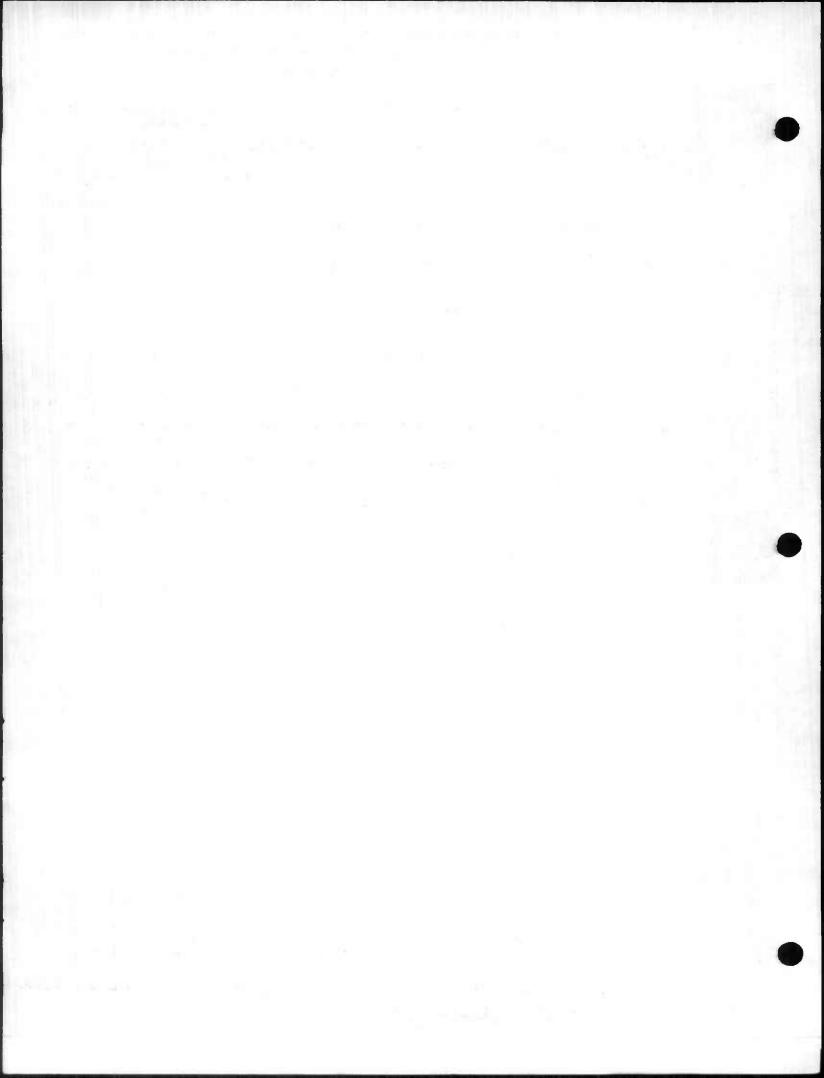
State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** January 18, 1999 1:52 PM Bernand /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville MDMontgomery 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Under 24 Hrs. 5. Social Sacurity Number 6. Sax 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Deys Hours 15€M 2□ F Yrs Director 577-36-7909 68 3, 1930 Washington, DC Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle Peges 1 end 2 should be filed within 72 hours after death with the Maryla neat of Health end Mental Hygiene. It is marked other than "naturel", or items 23a or 28a-f shown in yor other traumatic event, its waster Examine found to invited. 1 TYes 2 No. Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15107 Interlachen Drive, Apt 323 20906 USA Funerai 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XYes 2 No if Yes, Give Year or Dates: Korea 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Specify only highast grada completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) President Printing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maldan Surname) Be Gregory J. Bussink Lillian Blinkhorn 19b. Meiling Address (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) (wife) 15107 Interlachen Drive, Apt. 323, Silver Spring, MD Marilyn J. Bussink 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If eny Injury or once. Gate of Heaven Cemetery 1/22/99 Silver Spring, MD

22. Name and Address of Facility Francis J. Collins Funeral
Home, Inc. 500 University Blvd. West 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensea Silver Spring, MD 20901 23a. Part1. Entar the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Cardiac Arrest diseasa or conditio resulting in death) Examiner Due to (or as a consequence of): Examiner Myocardial Infarction hours ician end burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in deeth) Lest Due to (or as a consequence of): CAD physician s the burial Box 68760. years Physician/Medical Due to (or as e consequence of): P.O. I signed by the e Part Ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XJnknown Records. þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? pege 2 s 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA this funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending Investigation To the Hospital or within 24 hours effer death.

To the Funeral Director: Aft 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 🗌 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier Medicai 29b. Signatura and title of certifier 29c. Licensa number 29d. Date signed (Month, Dav. Year) 30. Name and a dress of person who completed cause of death (Item 23e) (Type, Print) 9901 Medical Center R. Rocarille, mb 20850 Eugene S panguola mb 31. Date filed (Month, Day, Yeer) State JAN 20 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Blizzard Charles Harry Evan 15:13 15 January 1999 4a Facility Name (If not institution, give street end number) Carroll County General Hospital 4b. City, Town, or Location of Death 4c. County of Death Westminster Carroll If Undar 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Dec 13 1922 5. Social Security Number 217–12–5278 7. Aga (In yrs. lest birthday) 76 Yrs. If Undar 1 Yaar Birthplaca (Stete or Foreign Country) X□M 2□F Months Days Yrs. Md. Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Insida City Limits Carroll Sykesville 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6015 Oklahoma Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forcas? 1 to Yes 2 □ No 1941 – If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2^{Collega (1-4or 5+)} Elementery/Secondery (0-12) carpenter construction 18. Mother's Name (First, Middla, Maiden Sumema) 17. Father's Name (First, Middle, Last) Charles R. Blizzard Mildred Hipsley 19a. informant's Name/Raiationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mildred Blizzard (spouse) 6015 Oklahoma Rd., Sykesville, MD 21784 20b. Place of Disposition (Neme of camatery, crametory or other place) Lake View Memorial 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from Stata 1-18-99 Sykesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Servica Licanti P.O. Box 195 Sykesville, Md. 21784 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Causa (Final disease or condition resulting in death) Brain 2 days , Ischemic 2 days amoxic Encephalopathy with seizures Due to (or as a consequenca of) Due to (or as a consequence of): Part ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to Depression completion of cause of death? 1 Yes 200 No 1 ☐ Yes 2 ☐ No 28. Piece of Death (Check only one)

Physician /Medical Examiner

physician and s the burial-transit

ed by the a

signed by to

been sir

s certificate has b director, page 2 s

al or Attending Physician: The ster death.

In Director: After this certificate ed in by the funeral director, pa

To the Hospital or within 24 hours aft To the Funeral Dil completely filled in

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medicai

by

Completed

Be

Certification: To

edicai

Physician

Examiner

Funeral

Director

with the Manyland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Med call Exacilise must be notified any longe.

/Medical

Md

Directo

Funeral

by

Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest

chronic obstructive pulmonary

25. Was case referred to medical examiner? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Dey Year) 28b. Time of 28c. fnjury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

27. Manner of Deeth 1 Natural 2 Accident 3 Suicide

5 Pending investigation 6 Could not be detarmined 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

29a. Certifier (Check only one)

4 Homicide

1🗹 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Msdical Examinar: On the besis of axamination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signatura and titla of certifian

29c. License number

29d. Date signed (Month, Dey, Year)

m.p.

D0052479

January, 15, 1999 30. Name and address of person who completed cause of death (item 23a) (Type, Print) LISA Kim, M.D. at carrell county general

Hospital 31. Dete filed (Month, Dey, Yeer)

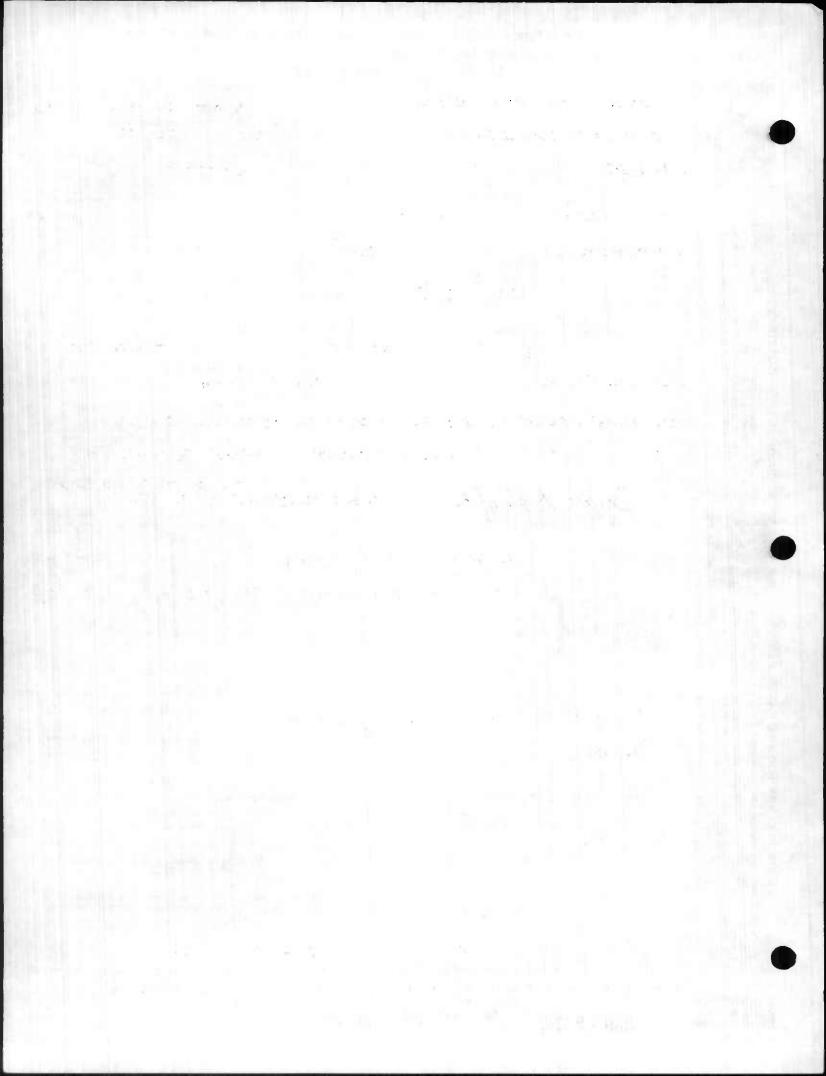
32. Registrar's Signeture

at 200 memorial Avenue, Westminster, MD 21159

State Registrar

JAN 1 9 1999

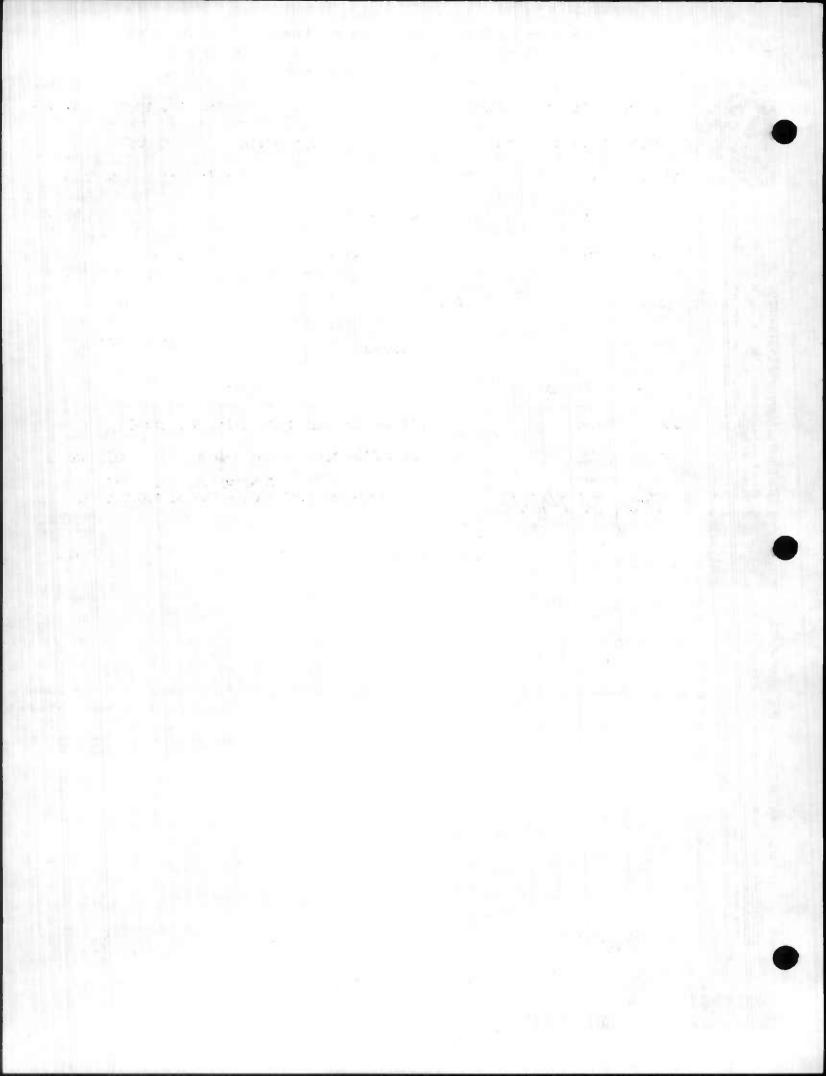




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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:47P.M. 18, .Tohn Joseph Bianca Jan. 1999 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Golden Age Guest Home Sykesville Carroll If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) May 5, 1912 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Hours 12 M 2□ F 86 Yrs. Director Maryland 217 26 4193 with the Maryland 10e. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at Md. Carroll Sykesville 1 ☐ Yes XIX No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 606 Trixsam Road 21784 U.S.A. Funeral death 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritei Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If fem 27 is marked other than "natural", or free any Injury or other traumatic event 1 2 Yes 2 No 1944— If Yes, Give Yeer or Dates: 1945 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No Specify Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) Hair Cutting Barber 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Agelo Bianca Giovanna 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John A. Bianca (son) 606 Trixsam Rd. Sykesville, Md. 21784 20b. Piece of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1X Buriei 2 ☐ Cremetion 3 ☐ Removel from State Dulaney Valley Mem. Gardens 1-21-4 Baltimore, Md. 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility Sykesville, Md. 21784 21. Signeture of Funeral Service Licensee, Haight Funeral Home & Chapel P.O.Box 195 caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth **Physician** Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Examiner certificate be asscuted physician and the burial-transit Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 200 USB 0 signed by the a 23b. Did tobacco use contributa to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 PUnknown 1 TYSS 2 No Division of Vital Records, þ 24b. Were eutopsy findings evelleble prior to 24a. Wes en eutopsy performed? Completed completion of cause of deeth? page 2 s certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Wes case referred to medical exeminer? Be 28. Piece of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury at Work? Certification: 1 Neturel 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 🖰 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as stated. 29e. Certifier edicai 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only within 2 To the \$ 29d. Date signed (Month, Dey, Year) 29b. Signature and titly of certify 29c. License number 0 99 30. Nemy and eddress of person who-completed cause of deeth (item 23e) (Type, Print) HTRUCK ELDONSBURG, MP LURNOS 40 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar



99-0305-013

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

10f. Zio Code

ONALD	2-11-99 WR State of Maryland / Department of Health and Ment ITEM: #28F PER MEO G768 2-4-99 Certificate of Death	tal Hygiene	02516
BUNCH	ITEMS: #23 PART 1, 27, 28A-F PER MEO G768 Certificate of Death	Reg. No.	() [() I ()

Physician /Medical	Decedent's Neme (First, Middle, Last)
Examiner	4a Facility Name (If not institution, give s
	CAPPOIT COINTY CENT

DONALD RAY BUNCH 4a Facility Name (If not institution, give street end number)

CARROLL COUNTY GENERAL HOSPITAL

JANUARY 20, 1999 4b. City, Town, or Location of Death

2. Date of Death

4c. County of Death CARROLL

Funeral Director

220-42-7094 Usual Residence of Decedent

7. Age (In yrs. last birthday) Months 1 M 2 □ F 53 Yrs.

If Under 24 Hrs If Under 1 Year 8. Date of Birth (Month, Day, Year) Hours 7/31/1945

WESTMINSTER

 Birthplace (State or Foreign Country) TENNESSEE

must be notified at

Herne 23a

il Hygiene. other than "natural", or item rent, the Medical Examiner.

. Pages 1 and 2 should be fit ment of Health and Mental Hant: If Item 27 is marked oth lury or other traumatic aven

Department of Important: If any injury or pace.

Physician /Medical

Examiner

physician and s the burial-transit

Director

Funeral

Completed

Be

2

Examiner

the Maryland

hours after

Baltimore, Maryland 21215-0020

10b. County BALTIMORE MD.

10c. City, Town or Location BALTIMORE 10d. Inside City Limits 1 ☐ Yes 2√ No

3. Time of Death

12:32P.M.

10e. Street and Number

5941 CENTRAL AVE. 12. Wes Decedent Ever in U,S. Armed Forces?

21207 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA. 14. Race - American Indian, Black, White, etc.

1 Never Married 2 Married 3 ☐ Widowed 4 ☑ Divorced

1 Yes 2 No If Yes, Give Year or Detes:

1 Yes 2 No Specify:

WHITE 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 9

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER

CONSTRUCTION

10g. Citizen of What Country?

Specify:

17. Father's Name (First, Middle, Last)

BUNCH, SR.

ORA

BLANTON

19e. Informent's Neme/Relationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

CASS BUNCH, JR. 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, cremetory or other place)

-BROTHER P.O. BOX 413, WEST FRIENDSHIP, MD. 21794 Date 20c. Location - City or Town, State MD.

1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

CREST LAWN MEM.GARDEN\$ 1/25/99 MARRIOTTSVILLE,

21. Signature of Funeral Service Licenses

CASS

22. Name and Address of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

18. Mother's Name (First, Middle, Maiden Sumame)

23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Immediate Cause (Final

ENVIROMENTAL HYPOTHERMIA COMPLICATING ALCOHOL INTOXICATION

Due to (or as a consequence of):

disease or condition resulting in deeth)

Due to (or es e consequence of):

Due to (or es e consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No

Approximeta Interval Between Onset and Death

Yes Yes 2 No 25. Wes case referred to medical 26. Place of Death (Check only one)

Hospitel: 1 ☐ Inpatien1 2 ② ER/Outpatien1 3 ☐ DOA 1 Yes 2 No

28b. Time of 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide ALONG RAILROAD TRACKS

EXPOSURE TO COLD ENVIRONMENT

281. Location (Street and Number or Pural Route Number, RT City of Towns Flete) 4 ENDAR RD. & JOHN ST.,

29a. Certifier one)

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number

29b. Signet

O.C.M.E.

JANUARY 21, 1999

nd address of person who completed cause of death (Item 23a) (Type, Print)

FON WELL MD

11 CARON 111 Penn Street, Baltimore, Maryland 21201

31. Dete filed (Month, Day, Year)

32. Registrar's Signeture

Sports

DHMH 16 Rev 6/95

State Registrar

ORIGINAL

Box 68760 0 ۵. Records, Division of Vital

requires that the death certificate be executed Physician/Medicai signed by the a by Completed page 2

Attending Physician: funeral director this

an 24 hou.

To the Within 2 To the

9

Be Certification: To death. after deat Director:

27. Menner of Deeth 1 Netural 2 X Accident

5 Pending investigation

Found: 1-20-99

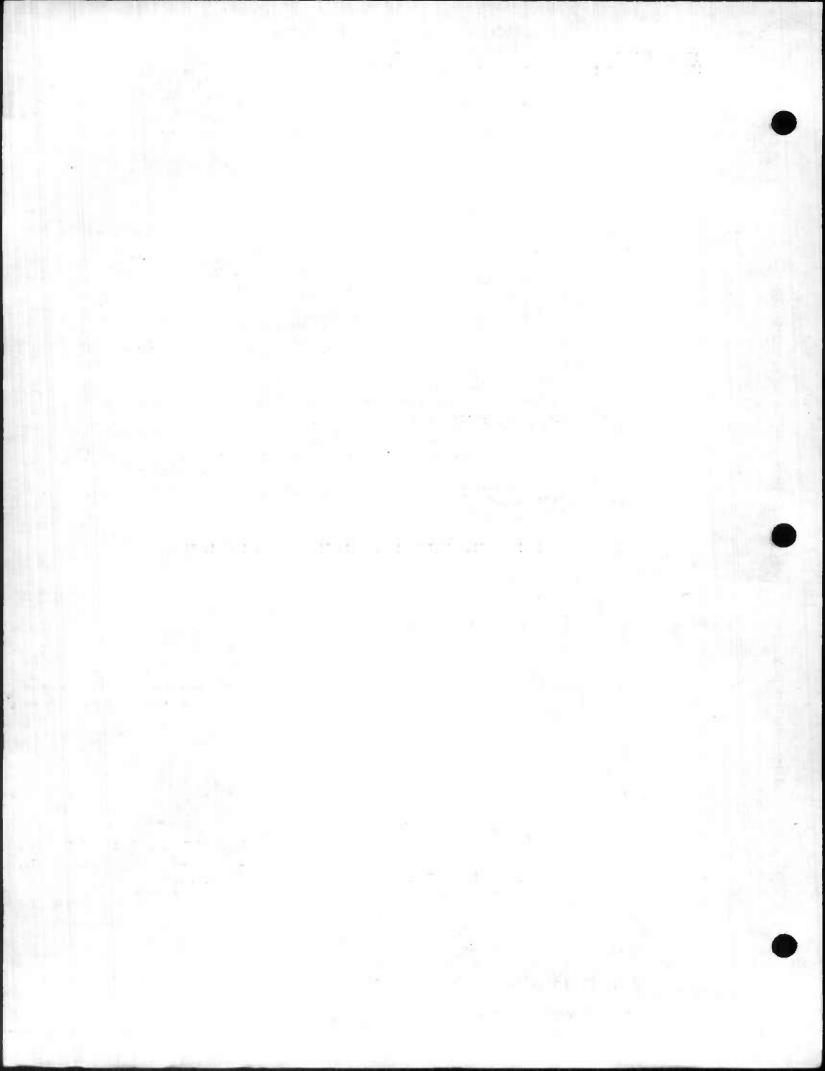
UNKNOWN

1 Yes 2 No

CARROL CO., MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

29d. Date signed (Month, Day, Year)



99-0245-019 cm Tan

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

	1.	Decedent's Na	ma (First, Middla, Li				Certificate			2. Data of D			3. Tima of Death
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al er	4a		(If not institution, gi	va street and num	ber)			4b	. City, Town, or	Janua Location of Dea	th 4c. C	1999 punty of Dec	9:45 A.1
	4	11 Pine	Street						Cambrid	lae	Do	rches	ter
		Social Security	Number 6.	Sex 7	7. Aga (In yrs		Months	1 Year Deys	Cambrid If Under 24 Hrs Hours Min	8. Data of B	rth	9. Bir	tholace (Stata or Forei
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		ual Rasidence a. Stata	10b. County		10c. C	ity, Town	n or Location						10d. Inside City Limi
			Domohoo	***	C	ambr	idge						1⊠Yas 2□N
-		aryland B. Street and N	Dorches	ster	1 0,	ambr	10f. Zip (Code			10g. Citize	n of What C	ountry?
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ı		1 💢 Nevar Me	rried 2 Married	Armed Ford	2 No					to Hican, atc.)		Black, Whi	ta, atc.
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			Name/Ralationship				. Mailing Addrass						
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	200	1 D Burial 2	Cremation 3			cematai	y, cramatory or oth	har place					
	04		5 Othar (Speci			Bet	hel Ceme			1/23/99	Cambr	idge,	Maryland
	21	. Signature of F	unaral Sawiee Lies	ntee			22. Name end	Address	of Fecility				
							Benni	e S	mith H	uneral	Home		
	Im	mediata Cause		nplications that ca r ona causa on aa	usad tha dea ch lina.	ath. Do r	Benni P.O.B	Box 1	687, Eas	ton, Mar	yland	21601	Approximata Interval Between Onset and Death
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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Amend #20b, 1/20/99, BMW, Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** IAMONCONR' 5:30 PM 1 ad /Medical 4e. Fscility Name (If not inetitution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner IANOR CHEVY CHASE TLOMER ARE NURSING HomE 01 If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Jan. 12 Birthplace (State or Fore Country) 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) **Funeral** Months Deys Hours 1□M 2以F 91 Yrs 113-07-7937 Director 1908 South Dakota Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits rel', or items 23s or 28s-f shore Examiner must be notified at none none 1 Yes 2 □ No Washington, D.C. Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2701 Connecticut Avenue, N.W. #608 20008 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a and Injury or other traumatic event, the Medical Examinations. U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 K Never Married 2 ☐ Merried Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Radio, Television Elementary/Secondery (0-12) College (1-4or 5+) Writer and U.S. Government 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Joseph Conry Ella Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ruth L. Barth / Friend 2701 Connecticut Ave., NW #608 Washington, DC 20008 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date Resurrection Cemetery January 2009 Mendota Heights, Minn. 1 X Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW Washington, DC 20007 23a. Part Lenter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Intarval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) Examiner Examiner law requires thet the deeth certificate be executed end Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting In death) Lest Due to (or as a consequence of) physiclen er s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of). 08 for use es signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 HO 3 Probably 4 Unknown þ been sig 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Was an autopsy page 2 certificate has The 1 Yes 1 ☐ Yes 2 ☐ No Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 20 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner el 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation iniun death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not ba determined in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter 4 Homicide ò filled Within 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) and manner es stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and left of confine 29d. Date signed (Month. Dev. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Av Chery Chave OSER M.D. mas

State

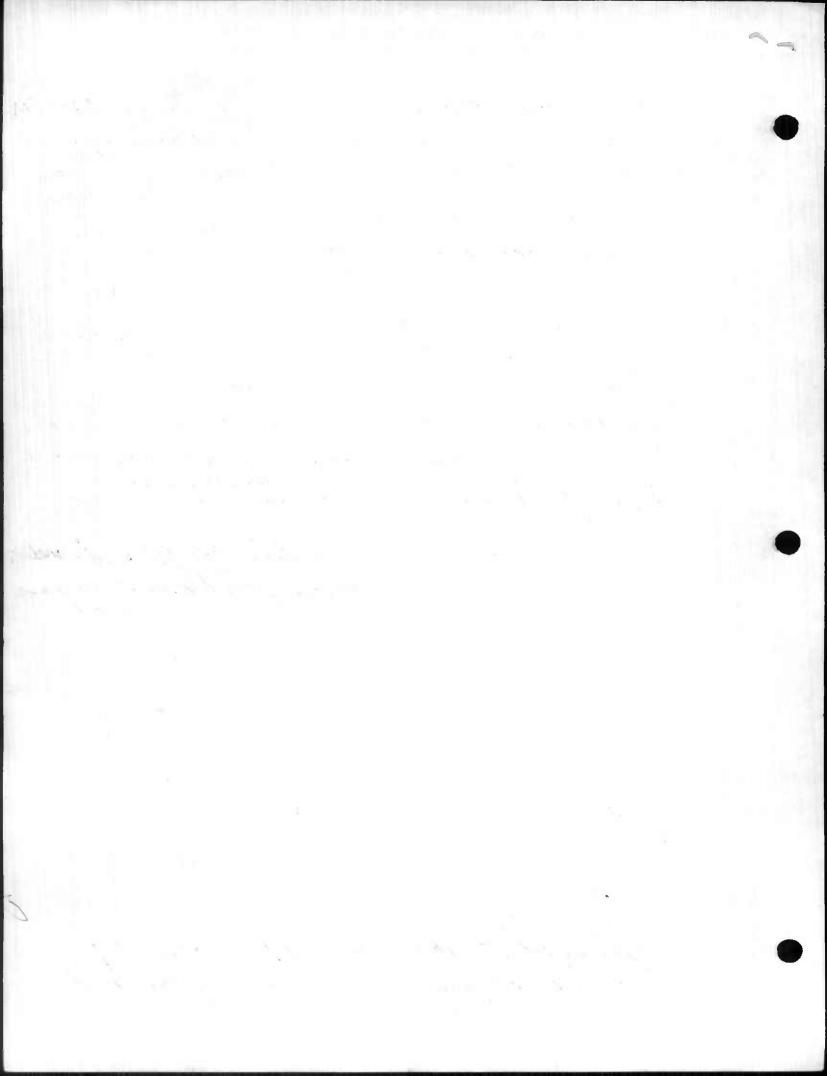
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31. Date filed (Month, Dey, Year)

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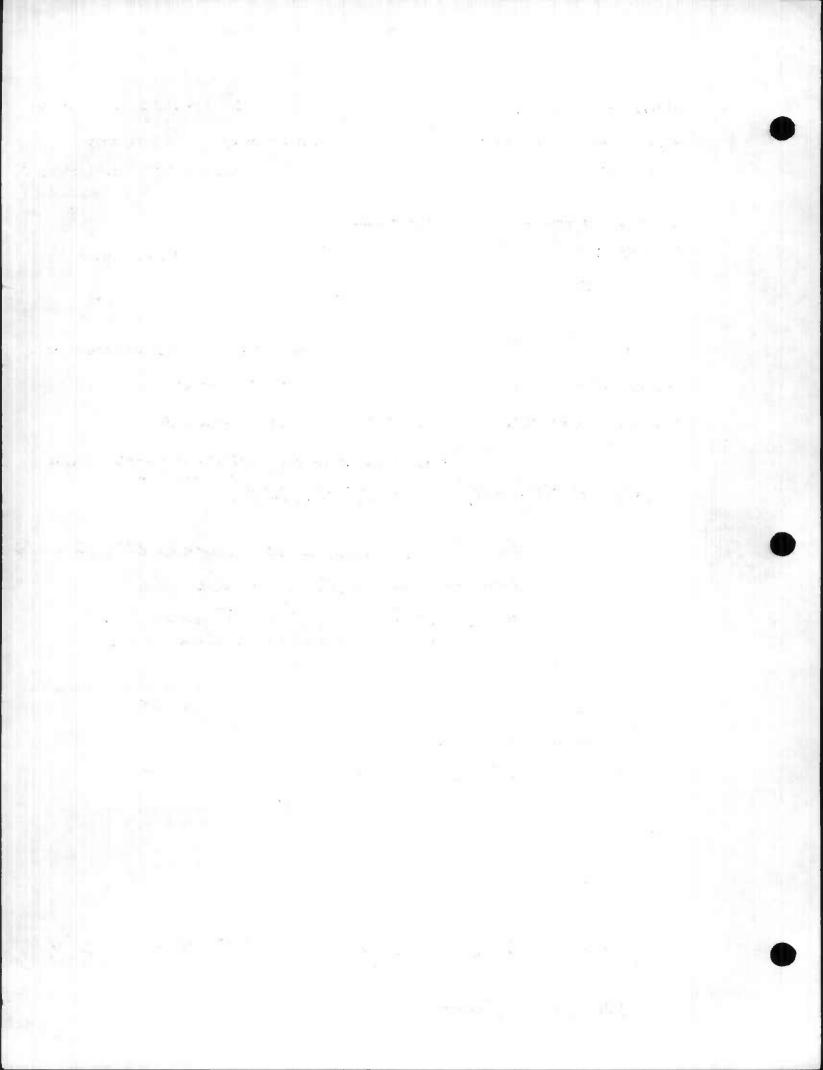
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32. Registrer's Signeture



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	Physician /Medical Examiner	Alfred Sampso		rumber)			4b. City		January eation of Deeth		999	1:00pm
	LAdminer	Wilson Health	Care Cent	er			Gai	thersb	iro	Mont	gomer	rv
	Funeral Director	5. Social Security Number 579-05-4663	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. le	st birthday) Yrs.	If Under 1 Months	Year If U	nder 24 Hrs. urs Min.	8. Dete of Birth (Month, Dey, Aug. 13	Year)	9. Birthp	lece (Stete or Foreign
	2	Usuel Residence of Decedent										
	th with the Marylan 23s or 28s-f show units motivised at	10e. Stete 10b. Cour	nty	10c. City,	Town or Loc	ation					1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-fa	Maryland Mont	gomery		Gaithe					0. 0	10-10	
	Dire					10f. Zip C	20877		'	0g. Citizen of		
	sath sa 23.	11. Meritel Stetus		cedent Ever in U.S	13 W	as Deceder		o Orlain? (Sne	cify Ves or No-	United	Stat æ-Americ	
21215-0020	72 hours after death with the Maryland natural; or items 23s or 28s-1 show iteal Examinet must be notified at the by Funeral Director	3 ☐ Widowed 4 ☐ Divord	Armed I	Forces? 2.X.No Give			Cuben, Me No Spe		cify Yes or No- Rican, etc.)		ck, White,	etc.
5-0	72 hours natural', fical Exi	15. Decad	lent's Education hest grade completed	4)	16e. Decede	ent's Usuel (Occupation	most of working	ng .	16b. Kind of B	usiness/Ind	dustry
21	ed within 72 ho ygjana. er than "natur. ft, fre Medical.	Elementery/Secondary (0-12		(1-4or 5+)				most of working				
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Ma	d 2 sho th and 7 is m traum	19a. Informent's Neme/Reletic							l Route Number	-		Code)
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Baltimore	Pagas nant of nt: If it nry or o	1 🗆 Buriel 2 🕅 Crematic		n State	metery, crem			1:				
E		4 Donetion 5 Other 21. Signature of Funeral Servi	***	Met	ropoli			ry 1	/22/99 / Vol Fund	Alexand	ria,	Virginia
Ba	permit. Departminportal any inju	Robert	A CWe	Not	10 Ga	East	Deer sburg.	Park D:	rive 877		me	
		23e. Pert1. Enter the diseese shock, or heart failure. L	or complications the ist only one cause or	caused the deeth.	. Do not ente	r the mode	of dying, suc	h es cardiec o	r respiratory err	est,		Approximete Intervel Between
8	Physician		1	4			,	. 1	. 7			Onset end Deeth
	/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)	0.	ules	my	1 ca	edi	al	certo	rel	em	Henrile
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P.0	that the de ted by the a datached	1224	222 / 1/			, ,			1 U Y	es 2 1 No	3 □ Prol	bably 4 Unknow
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Division	aftar da Directo d in by th	3 ☐ Suicide 6 ☐ Cou	lld not be ermined 28e. Pla	ca of Injury - At hor ding, etc. (Specify)	me, ferm, stre	et, fectory,	office	2	28f. Location (Si City or Town	treet end Num	ber or Rure	al Route Number,
Ö	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	. /	, Bui	ung, etc. (<i>Specify</i>)					ony or rom	,, 0,0,0)		
	To the Hospital or within 24 hours afte To the Funeral Dir complatally filled in Medical Cert	29a. Certifier 1 Certification (Check only one)	ying Physician: To the	ne best of my know basis of exeminetion onner steted.	ledge, deeth on end/or inv	occurred et estigetion, ir	the time, de my opinion	te end plece, e , deeth occurre	end due to the co	euse(s) end m ete end place,	enner as s end due to	teted. the ceuse(s)
	ithin of the complete Me	29b. Signeture and title of cert		mor stotos.		200 1	License num	ber	2	9d. Date signe	d (Month,	Day, Year)
						236.						
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G. Sports

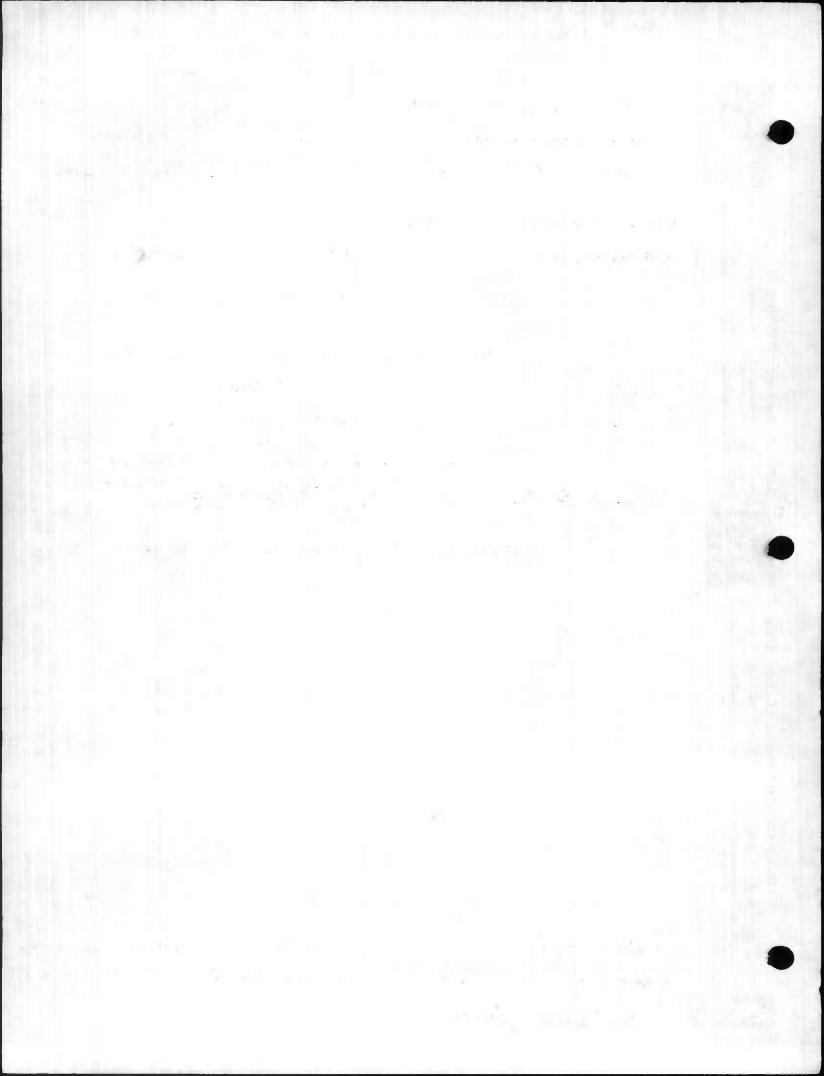


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State of Maryland / Department of Health and Mental Hygiene 9

			Certificate	e of L	Death		Reg.	No.		0 0		
1. Decedent's Name (First, Middle,						2. Date		Day	Year	3. Time of D		
Medical JAMES Ro	GER CLI	FTON	J				LARY	19	1999	0221		
aminer 4a Facility Nama (If not institution,				4		m, or Location of	-	4c. County				
Montgomery Gene	ral Hospita	a1			01ney				gomer	У		
538-30-7176	5. Sax 7. Ag 123 M 2□ F	e (In yrs. last bir 65	thday) If Under Yrs. Months	1 Yaar Days	If Under 2 Hours	4 Hrs. 8. Date (Mont	of Birth h, Day, Ye L 12,	1933	Count	aca (State or iny) ington		
Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location						10	od, fnside City		
			ville							1 Yas		
Maryland Montgo	omery	ROCK	10f. Zip	Code			100	Citizan of V	Vhat Coun	in/2		
Maryland Montgo	ad			0853	3			nited		-		
11. Maritaf Status	12. Was Decedant	Ever in U,S.				in? (Specity Yas Puarto Rican, etc	or No-		e - Amarica			
3 ☐ Widowed 4 ☐ Divorced	Armed Forces? d 1 Yes 2 If Yas, Giva Year or Dates:		If Yas, speci		n, Mexican, Specify:	Puarto Rican, etc	:.)	Specify	k, White, c	ite		
15. Decedent's (Specify only highest Elementery/Secondary (0-12)	Education	16a.	Decedent's Usua (Give kind of work	1 Occupa	ation	of working	16b	. Kind of Bu	siness/ind	ustry		
(Specify only highest Elementery/Secondary (0-12)	College (1-4or	5+)	life. DO NOT us	e retired)	or working						
00	5+	Re	search S	cier				.S. G		ment		
17. Fathar's Name (First, Middle, L.						's Name (First, M		den Sumem	e)			
George R. Clifto						Drebic						
19e. Informant's Name/Relationshi		1	. Malling Address									
Eva Maria Clifto	on/Wile		008 Norbe				00.	c. Location -				
20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donetion 5 Other (Spe			f Disposition (Namery, crematory or of omery Cre	emat	orium	, Inc.	Bet	thesda	, Mai	ryland		
1 Burial 2 Cremation 4 Donetion 5 Other (Spotsor) 21. Signature of Funeral Service	21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Roc 300 West Montgomery Avenue Rockville, Maryland 20850-2805											
23a. Part1. Enter the disease, or conshock, or heart failure. List of	omplications that cause	d tha daalh. Do	not enter the mode	e of dyln	g, such as c	ardiac or respirat	ory arrest,		Ī	Approximete Interval Betw		
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Part II. Other significant condition												
2						24a.	Was an a			ere autopsy fir allabla prior to		
Completed							portonito	.	CO	mpletion of ca death?		
E C							1 Yas	2 No	10	Yes 201		
25. Was case referred to medical					26. Place	of Death (Check						
axaminer? 1	Hospital: 1 ☐ Inpatie	ent 2 ER/O	utpatient 3 DO	A Oth	00'	sing Home 5		e 6 Oth	er /Specifi	v)		
	28a. Date of Inju (Month, Da			8c. Injun		28d. Des		injury occur				
3 Suicide 6 Could no determin	ar 206. Flaca Ul III	jury - At home, fa tc. (Specify)	arm, street, fectory	, office			tion (Stree or Town, S		er or Rura	I Route Numb		
	Physician: To the best xaminer: On the bests o and manner st	of examinetion an										
29b. Signature and title of cartifier	250				e nu <i>m</i> ber			. Data signe				
1 Anny	w			D3	7891		JI	ANUA	RY :	20 10		
30. Neme end address of person w	ho completed cause of c	death (Item 23e)	(Type, Print)	nal	LN	#409	P	ockv	ille,	MD-		
31. Date filed (Month, Day, Year)		rar's Signature										

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Amend #8, 1/22/99, BMW, Montg. Co. Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** CHAI 0 0530 A JANUARY 14 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Shady Grove Adventist Hospital Rockville MD Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth 5 – 27 – 219. Birthplece (State or Foreign Months Deys Hours Min. Month, Day, Year) Country)

May 21. 1921 China 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1₩ 2□ F Yrs. Director 216-04-6557 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery 01ney 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4111 Cherry Valley Drive 20832 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or their any Injury or other traumatic event, the Medical Example. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: by Specify: 3 ☐ Widowed 4 ☑ Divorced Asian Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) Pilot Chinese Air Force 17. Fether'e Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be "Unknown" Zi Zen Chai 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) En Wei Chai, Son 4111 Cherry Valley Drive, Olney, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Jan 15, 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 5 Other (Specify) Metropolitan Crematory 1999 Alexandria, Virginia uneral Service Licensee 22. Name and Address of Fecility DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, 20877 elus or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, lst only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final METASTATIC PROSTATE CANCER 2 YEARS disease or condition resulting in deeth) Examiner Due to (or es e consequenca of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Due to (or as a consequence of) 88 use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed Be

physician and s the burial-transit that the death certificate be executed P.O. Box 68760. signed by t Division of Vital Records. Hospital or Attending Physician: The law requires to 24 hours efter death.

Carboral Director: After this certificate has been sign elegify filed in by the funeral director, page 2 should be leiely filed in by the funeral director, page 2 should be Certification: To

the Maryland

Baltimore, Maryland 21215-0020

							24e. Wes en eutopsy performed?	24b. Were autopsy findings evaileble prior to completion of cause
							1□Yes 2₽No	of deeth?
	Wes case referexeminer?	red to medical				26. Plece of D	eeth (Check only one)	
	1 ☐ Yes 2 ☑	No	Hospitel: 1 Impatient 2	ER/Outpetient	3□ DOA	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	er (Specify)
	Manner of Deet 1 DNaturel 2 Accident	5 Pending investigation		28b. Time of Injury	280 M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how Injury occur	red
	3 Sulcide 4 Homlcide	6 Could not be determined	28e. Plece of Injury - At the building, etc. (Special	nome, farm, stree	t, factory,	office	28f. Location (Street end Numb City or Town, Stete)	per or Rural Route Number,
296	Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of my known the common state of my known the common state of the	owledge, deeth o etion and/or inve	occurred et stigation, in	the time, date end plea my opinion, deeth occ	ce, end due to the cause(s) end me curred at the time, date end placa,	enner es steted. and due to the cause(s)

State

Registrar

29b. Signature and title of cartifier

29c. License number D32407

29d. Dete signed (Month, Dey, Year) JANUARY 14, 1999

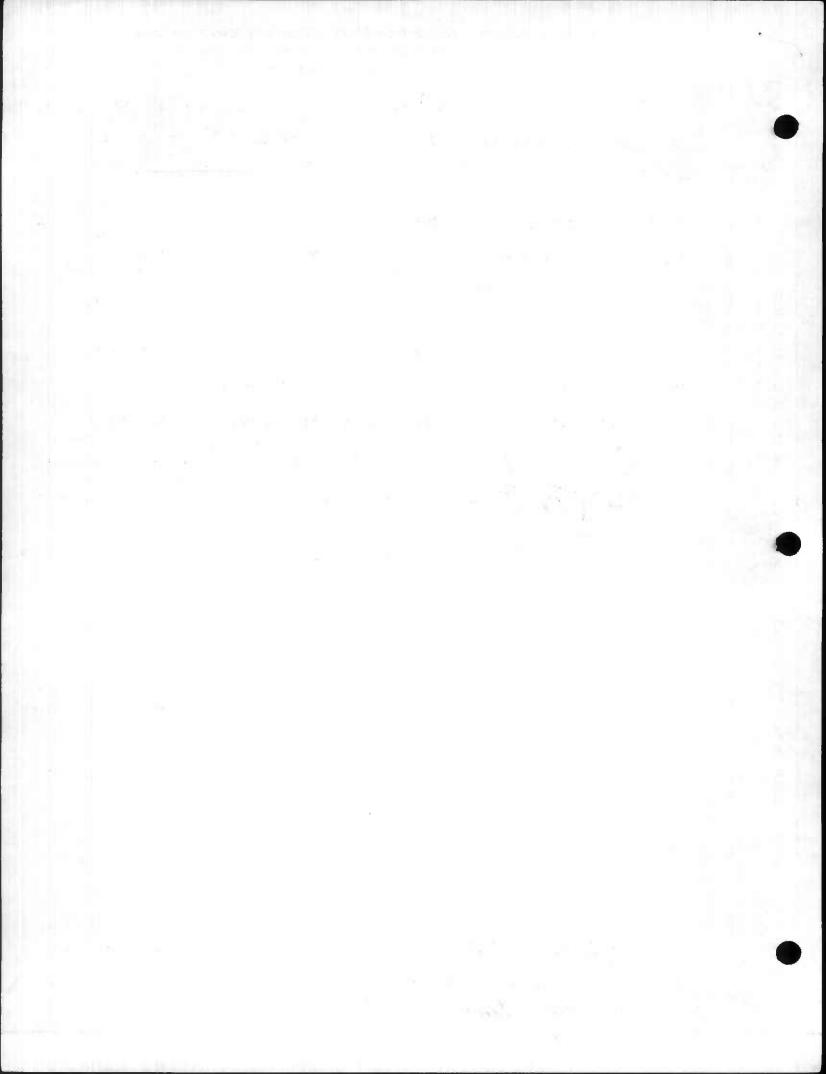
30. Name end eddress of person who completed cause of deeth (tem 23e) (Type, Print)

JOSEPH M. HAGGERTY MD 9707 MEDICAL CTR DR ROCKVILLE MD 20850 31. Dete filed (Month, Dey, Year)

JAN 19 1999

32. Registrer's Signeture

To the Vithin 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔍 🔾 Certificate of Death 1, Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tims of Death Month **Physician** Charles Cain 1999 01 12 08:20AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Deeth Examiner Burtonsville, Montgomery MD Holy Cross Rehab & Nursing Center of Secretary Number 1 Secretary Numb H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □XM 2 □ F 157 18 5515 Director 16, 1927 Kingsport, TN Usual Residence of Decedent death with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic svent, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10000 Brunswick Avenue #122 20901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XXX/es 2 No 46-4 If Yes, Give and Yeer or Dates: 52-5 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter of Department of Health and Mental Hygiene. Importants if then 27 is marked other than "natural", or item any finury or other traumatic svent, the Medical Examina 6-47 and 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced **Black** 52-54 Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Walter Reed Army Elementery/Secondary (0-12) College (1-4or 5+) Biochemist Institute of Research 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Elias Cain Stella Cartwright 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 7503 Harrison Lane Temple Hills, MD 20748 Marilyn Cain Gordon/Daughter 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donetion 1/19/99 Triangle, Virginia Quantico National 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. une e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximete Intervel Between Onsef and Death Physician /Medical disease or condit resulting in seath Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last -pari and Box 68760 physician Physician/Medical 8 Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Donknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 DNeturel 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 - Homicide 24 hours e 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) completely To the within 2

State Registrar

10

31. Date filed (Month, Dey, Year) JAN 1 9 1999

humache

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signeture end fitte of certifier

2309 32. Registrer's Signeture

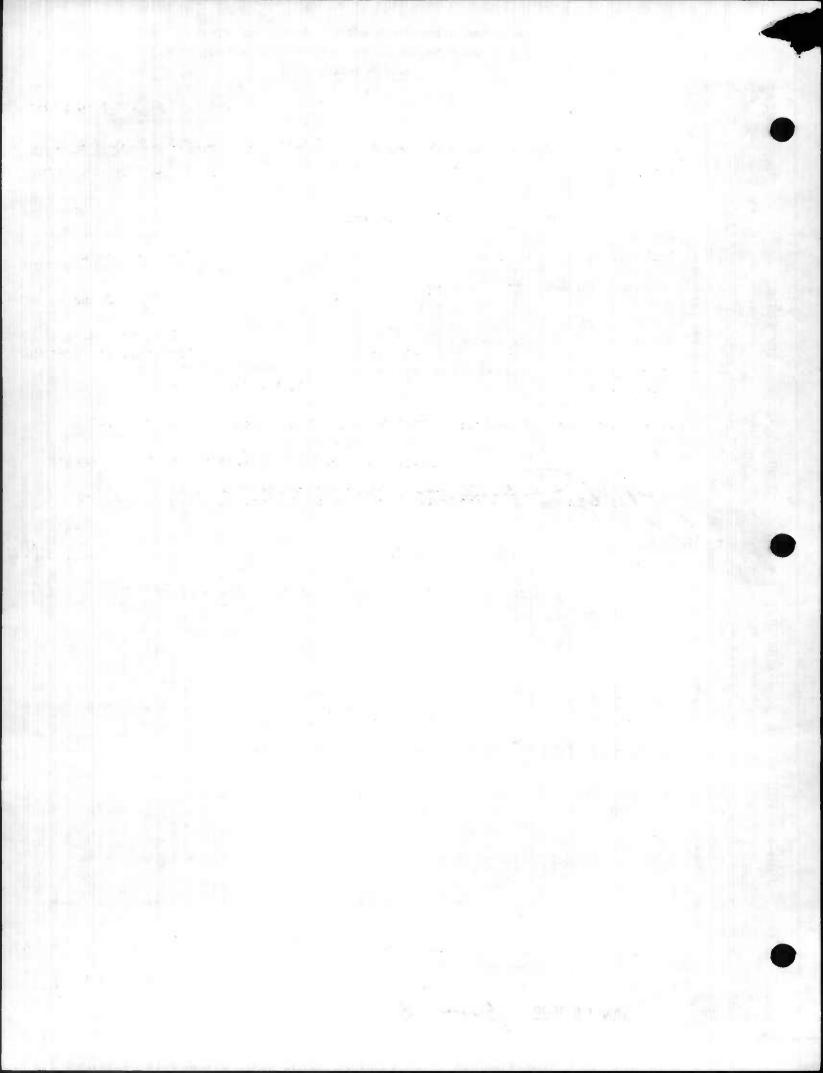
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29c. License number

Wheat

29d. Date signed (Month, Dev. Year)

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Dev Carroll Jan. 10, 1999 9:35PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Collingswood Nursing Center Rockville Montgomery If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs. Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Months 1 M 2 F 76 152-20-3117 Yrs Director SEPT. 13, 1922 NEW JERSEY Usual Rasidence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at MD Director 1 Yes 2 □ No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 229 Hurley Avenue 20850 U.S.A. Funeral filed within 72 hours aftar death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Rieck White etc 1 Never Married 2 Merried 1 ☐ Yes 2 ▼No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🙀 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked othe any Injury or other traumatic event. 17. Fethar's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumame) Be Bill Carroll Yvonne Wealth 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Streat and Number or Rurel Routa Number, City or Town, State, Zip Code) Elsie Bittorf /power of attorney 17060 King James Way #410, Gaithersburg, MD 20877 20b. Piece of Disposition (Neme of cemetery, cramatory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 1/20/99 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) Mount Comfort Crematory 21. Signature of Funerel Service Licentee 22. Name end Address of Fecility
Affordable Funeral Service 2230 Gallows Road Suite 110 Dunn Loring, VA 22027 the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each lina. Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Final diseese or condition resulting in death) Uremia 1 month Examiner Due to (or es e consequence of): Examiner Arteriosclerotic Vascular Disease The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Ceuse (Disease or Injury Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Was en eutopsy performed? has 1 ☐ Yes 2 H No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case raferred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No this funeral 27. Manner of Deeth 1 ≅ Neturel 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28d. Describe how injury occurred After 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: completaly filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 - Homicide Hospital tion in the best of my knowledga, daath occurred et tha tima, date end plece, end dua to tha cause(s) and manner as steted.

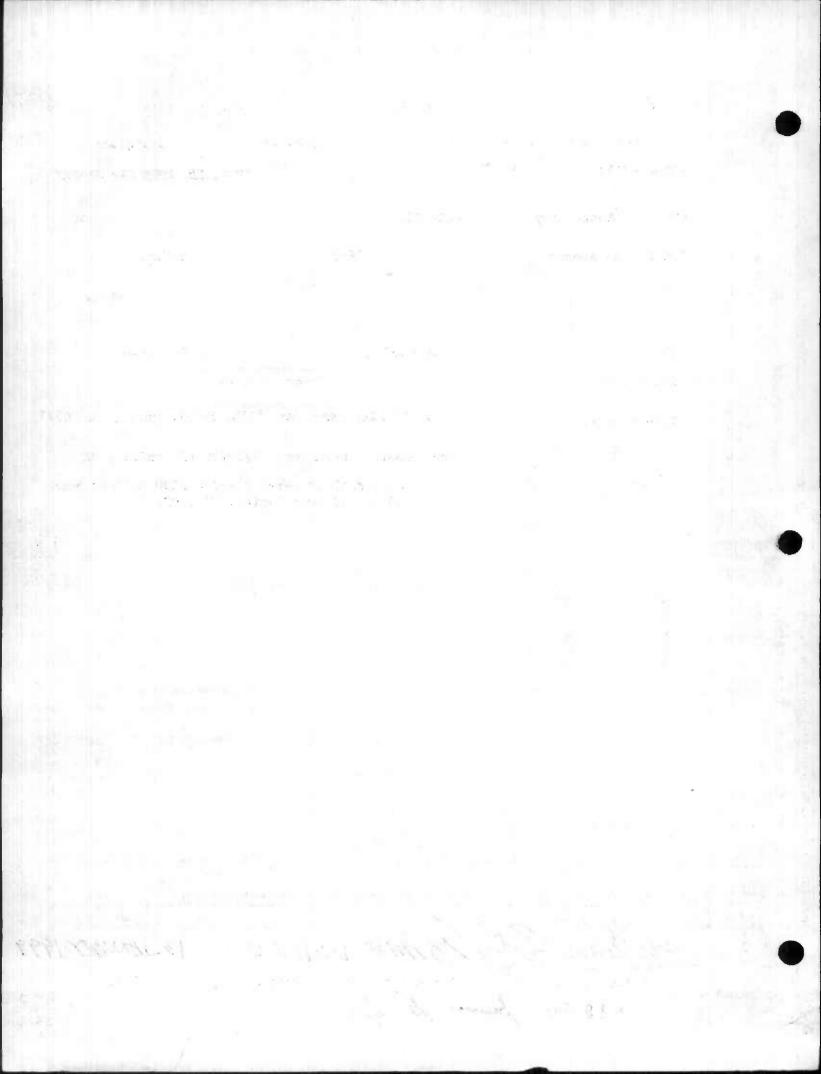
□ Medicat Examiner: On the basis of axeminetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted. Medical 29e. Cartiflar (Check only one) 29b. Signeture a 29c. License number 29d. Dete signed (Month, Dey, Year) 0 30. Neme end eddress of person who completed cade of death (Hem 23a) (Type, Print) 1299 Lamberton Dr., Silver Spring, MD 20902-3411 Walter E. Goozh MD., 31. Deta filed (Month, Day, Year) 32. nagistrer's Signature

DHMH 16 Rev 6/95

State

Registrar

JAN 19 1999

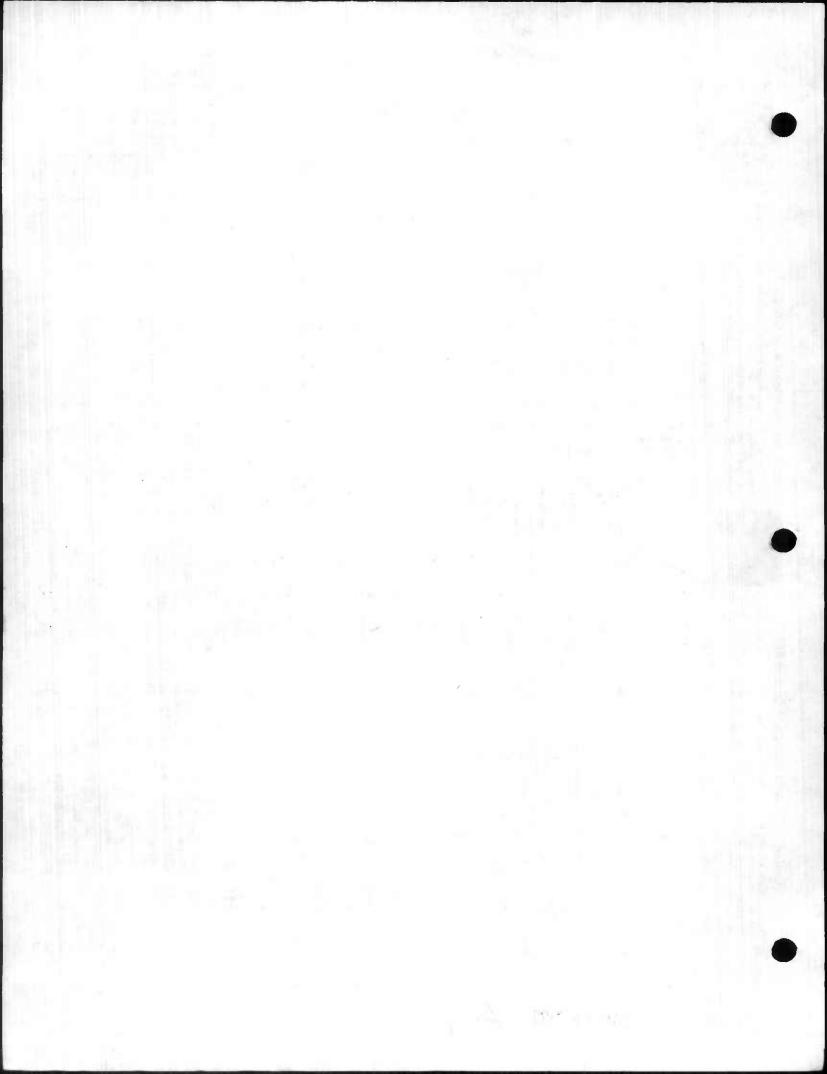


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State of Maryland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle, L.	ast)	C	Certificate	OI	Deali		2. Dete of Deat	eg. No.		3. Tima ot Death		
Physician	James Edward							Month January	18, 19	Year QQ	8:55 AM		
/Medical	4e Facility Neme (If not institution, gi)		- 4	4b. City, To	wn, or Lo	ocation of Death	_	County of Death			
Examiner	Holy Cross Hospi				1	Silve			Montgomery				
uneral irector		Sex 7. A 1⊠ M 2□ F	ge (In yrs. last birtho	Months	1 Year Days	If Undar	24 Hrs. Min.	8. Date of Birth (Month, Day, Jan. 19,	Year) 1911	9. Birthp Coun West	lace (State or Foreign ltry) Virginia		
	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				171.4	10d. Inside City Limits				
ust be notified at rai Director	MD Montgom	ery	Kens	sington						1 AYes 2 No			
al Dire	10e. Street and Number 3507 Farragut Av	enue		10f. Zip (20895		1	0g. Citizen of V US		itry?		
by Funeral	11. Marital Status 1 Nevar Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Detes:	Ever in U.S. No	13. Wes Decede If Yes, speci			gin? (Sp , Puerto			ce - American Indien, ick, Whita, etc. White			
pete	15. Decedent's E		16a. D	ecedent's Usuel Give kind of work	l Occup	ation	t of work	ina	16b. Kind of Bu	siness/Inc	dustry		
Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	n Catho	e retired	1)		Religiou					
Be C	17. Father's Name (First, Middle, Las)	, , , ,					e (First, Middle, M					
10	Luke Casey					Elizabeth Rowan							
	19a. Intormant's Neme/Relationship	(Type, Print) Nepl	ype, Print) Nephew 19b. Mailing Addrass (Stree								Code)		
	WIlliam P. Griff	in, C.F.X.			_	Aven	ue,	Kensing			895		
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 [crematory or of	her plac		1		20c. Location -				
8	4 Donation 5 Other (Special Signature of Funeral Service Lice		Gate of	22. Name end	Addra	ss of Fecilit	y Fra	/20/99 Sancis J.	Collin	s Fui			
Ž.	Maher	JQ.Co	le	Home, I				lversity 20901	BLvd.	West			
sician	23a. Pert1. Enter the diseese, or con shock, or heart teilure. List only	nplicetic in that cause one chan on each	d tha deeth. Do not ine.	ng, such as	cardiac	or respiratory arre	est,		Approximate Intervel Between Onset end Deeth				
eal ier	tmmediete Cause (Finel disease or condition resulting in death)			4 days									
Examiner		. Mult:	e Myor	cardia	1	Inf	arc	tion			4 Lays		
	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events		y Lays										
hed for use as the burish-transit ysician/Medical Examir	that initiated events resulting in death) Last												
be detached for use by Physician/A		d					, , , , , , , , , , , , , , , , , , , ,						
ysic	Pert It. Other significant conditions	contributing to death I	out not resulting in th	na underlying ca	use giv	en in Part I.				acco use contribute to the cause of death?			
by Pi								1 Y	98 2/SLNo	3 Pro	bebly 4 Unknow		
Completed							_	24a. Wes a perform	n eutopsy ned?	av	ara autopsy tindings allable prior to mpletion of cause death?		
Com								1 🗆 Ye	s 2 No	10	Yas 2 No		
Be	25. Was case reterred to medical examinar?				100		of Deat	h (Check only on	Θ)				
luneral director, page 2 s lon: To Be Comple	1 ☐ Yas 2 € No 27. Manner of Death 1 ☑ Netural 5 ☐ Pending	Hospital: the things of the th	ury 28b. Tim	a of 28	Bc. tnjur Wor	4L NU		oma 5 Raside 28d. Describe ho			y)		
Certification:	2 Accident investigation 3 Suicide 6 Could not to detarmined	28e. Plece of tr	jury - At home, farm ic. (Specify)			143 201		28f. Location (Street and Number or I City or Town, State)			al Route Number,		
completely filled in by the funeral di	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best miner: On the basis of end menner st	examination and/o	aeth occurred a r investigation,	it the tin	na, data an pinion, daal	d place, th occurr	and dua to tha cared at the time, da	ause(s) and ma ate end place,	nner as si	tated the cause(s)		
Me	29b. Signetury and titla of certifier	CNI		29c.		e number		2	9d. Dete signe	(Month,	Day, Year)		
-	▶ Kee Edwa	delib	ND		-	2299			Janu	arz	18, 1999		
	30. Name and address of person who Lee Edward	completed cause of Chwab	MO, (Ty	ly Cros	ss t	tosp.	tal	Silve	r Spr	ing	, Md 209		
State	31. Dete tiled (Month, Day, Year)		rar's Signetura	1 1)			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Daia of Death 3. Tima of Death Month 12, 1999 Claire Marie Cassatt January 9:55 P.M. 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Shady Grove Adventist Nursing Home Rockville Montgomery County If Undar 24 Hrs. Hours Min. 8. Daia of Birth (Month, Day, October If Undar 1 Yaar 9. Birthplaca (Stata or Foraign Country) 0 Pennsylvania 7. Aga (In yrs. last birthday) Months 1□ M 2 F Days 27,1900 98 Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Maryland Montgomery County Rockville 10f. Zip Coda 10g. Citizan of What Country? United States of America 20850 9701 Medical Center Drive 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No if Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedani of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 Navar Married 2 Married 1 Yas 2 No Specify: 3 Nidowed 4 Divorced White 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedani's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Teacher Education 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maldan Surnama) Annie Elizabeth Sheaffer 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Jack D. Neeley/ Nephew 26198 East 23rd Street, Highland, California 92346 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata Camp Hill, Data 1 Burial 2 □ Cramation 3 □ Ramoval from State January 4 ☐ Donation 5 ☐ Othar (Specify) Rolling Green Cemetery 16,1999 Pennsylvania 21. Signa/Ora of Funaral Sarvice Licensas 22. Nama and Addrass of Facility 17109 Hetrick Funeral Home ason 3125 Walnut Street, Harrisburg, Pennsylvania 23a. Part1. Enlar the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onsai and Death day Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ♦ Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was cesa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Skursing Homa 5 - Rasidance 8 - Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 TYas 2 No 6 Could not be 28a. Place of injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 38262

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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"natural", or items 23a

permit. Pages 1 end 2 should be filed within 72 hours after death valopartment of Haalth and Mentel Hygiene. Important: If them 27 is marked other than "natural", or thems 23 any injury or other traumetic event, the Madical Examiner must

Physician /Medical

Examiner

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page 2 certificata

filled In by tha funeral director,

Baltimore, Maryland 21215-0020

the Medical Examiner must be nothing at

Director

Funeral

by

Completed

Be

2

Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

with the Maryland

5. Social Sacurity Number

10e. Street and Number

David Neeley

20a. Mathod of Disposition

Immediata Causa (Final disaasa or condition resulting in daath)

Sequantially list conditions, if any, leading to Immadiata ceusa. Entar Underlying Causa (Diseasa or injury that initiated avants rasulting in death) Last

1 Yes 20 No

27. Mannar of Death

1 Natural 2 Accident

3 Suicide

29a, Certifian

4 Homicida

10a. Stata

175-34-8398

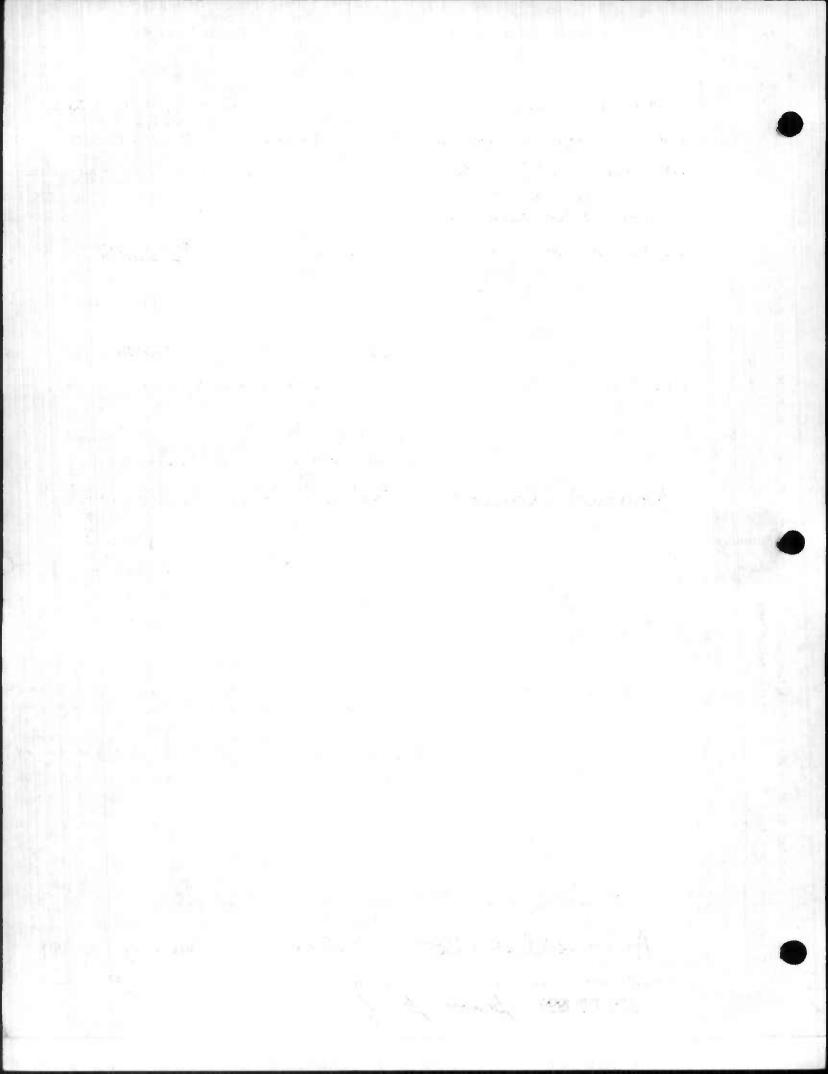
State Registrar

Dr Mendhiratta

18111 Prince Phelip 32. Registrar's Signatura

30. Nama and address of person who complated ceusa of death (itam 23a) (Type, Print)

Olney Suite 212, MD



99	0-0208-0 0-015 ERCEDES Amend				State o		d / Dep		fH	Assure Allealth and		lygie	ene 99	ole.	2526
		п	1. Decedent's Name (First, Mic				06	illicate (ו וכ	Dealli	2. Date of	Death	. No.		3. Time of Death
	Physicia: /Medica	_	MERCEDES		C.	CAS	TRO		_		JANUA		P3, 199	9 ^{ear}	5:33P.M.
	Examine	r	4a Facility Name (If not instituted 1350 ROCKVILLE			mber)			1	tb. City, Town, or ROCKVIL		ath	4c. County		
	Funeral Director		5. Social Security Number UNKNOWN	6. 3	Sex 1□M 2X F	7. Age (In yrs.	last birthday 24yrs.	If Under 1 You Months De		If Under 24 Hrs Hours Min				Cou	place (Stata or Foreign intry) SALVADOR
	Meryland f ahow	0	Usual Residence of Decedent 10a. State 10b. Cour MD MONTO		ERY		y, Town or L								10d. Inside City Limits 1 √Yes 2 No
		I Director	10e. Street and Number 631 BLANDSF(ORD	STREE	1		10f. Zip Coo		0		10g	Citizen of W	het Cou	intry?
020	or the	by runeral	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce		12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or D	2 X No	,S. 13	Was Decedent	of Hi Cuba	ispanic Origin? (! n, Mexican, Puer Specify:	Specify Yes or to Rican, etc.)		14. Race Black	c, White	can Indian, , atc.
1215-0020	d within 72 hours piene. r than "natural", re Medice Err	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	nest gr		-4or 5+)	(Giv	edent's Usual Oc a kind of work do DO NOT use re	one d	during most of wo f)			b. Kind of Bu		
land 21	# 1 45 P	00 00 01	7TH 17. Father's Name (First, Middle JUAN J. C		rro CRI	IJZ	100	J DERV		18. Mother's Na LUISA					
, Mary	nd 2 in the or tree		19a. Informant's Name/Relation MAXIMINA CRU)	196 Mai 631 ROC	ing Address (Sh BLAND KVILLE	SF	ond Number of R ORD ST MD. 20	ural Route Nu	nber, C	ity or Town,	State, Zi	p Code)
imore	Pages 1 end ment of Healt ant: if Item 2: ury or other		20a. Method of Disposition 1 Burial 2 Crematio 4 Donation 5 Other			State		osition (Name of emetory or other ERIO			Date 1 / 27 / 9		c. Location - C		
Balti	Department of Important: If I eny Injury or once.		21. Signature of Juneral Service	4	ten	Du	> 3	821 14	TF	DYSTER I STREE	T N.W	. , W.	ASH, D	c.	20011
	Physician /Medical		23a. Part1. Enter the disease shock, or heart failure. L	or com st only	plications that c one cause on e	aused the deet ach line.	h. Do not e	nter the mode of	dyin	g, such as cardia	c or respirator	y arrest		1	Approximate Interval Between Onset and Deeth
		Jer	disease or condition resulting in death)		a	Due to (c	or as a consi	equence of):			Ja	1_1	(C)	1	
,00	one on the control of	al Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S	b	Due to (o	or as a conse	equence of):						1	
ox 68760	physe the		that initiated events resulting in death) Last	J	d	Due to (o	r as a conse	quence of):							
P.O. B	d by the etter	À.	Part II. Other significant condi	tions o	contributing to de	eath but not res	ulting in the	underlying cause	e giv	en in Part I.				tribute	to the cause of death?
ecords,	\$ 20 g 1	completed by									24a. W	as an a	autopsy d?	a	Vere eutopsy findings vallable prior to ompletion of cause if death?
Vital R	leien: The li certificate he rector, page	D	25. Was case referred to medi	al						26. Place of De		Yes ly one)	2 No	1	®Yas 2□ No
01 <	ald al	2	examiner? 1 [X] Yes 2 No 27. Manner of Death		Hospital: 1 🗆 I	npatient 2	ER/Outpation		Oth	er: 4 Nursing	Home 5□R	esidend		-	ily) SCENE
Division	0 0 0	Brillication	1 Natural 5 Pend 2 Accident inve- 3 Suicide 8 Coul	stigatio	n 1/13	h, Day Year)	173		10	Yes 2 No	Pedes	n (Street	an St	ruc	k b y es Pumber.

Medical Certification: To Be Completed

To the Hospital or Attending Physicien: The lew requir within 24 hours effer death.

To the Funeral Director: After this certificate hee been a completely filled in by the funeral director, page 2 should

4 Homicide 29a. Certifier (Check only one)

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

Count Montgomery

29b. Signature and title of cartified

29c. License number O.C.M.E.

29d. Date signad (Month, Day, Year) JANUARY 14,1999

30. Name and addig completed cause of death (Item 23a) (Type, Print)

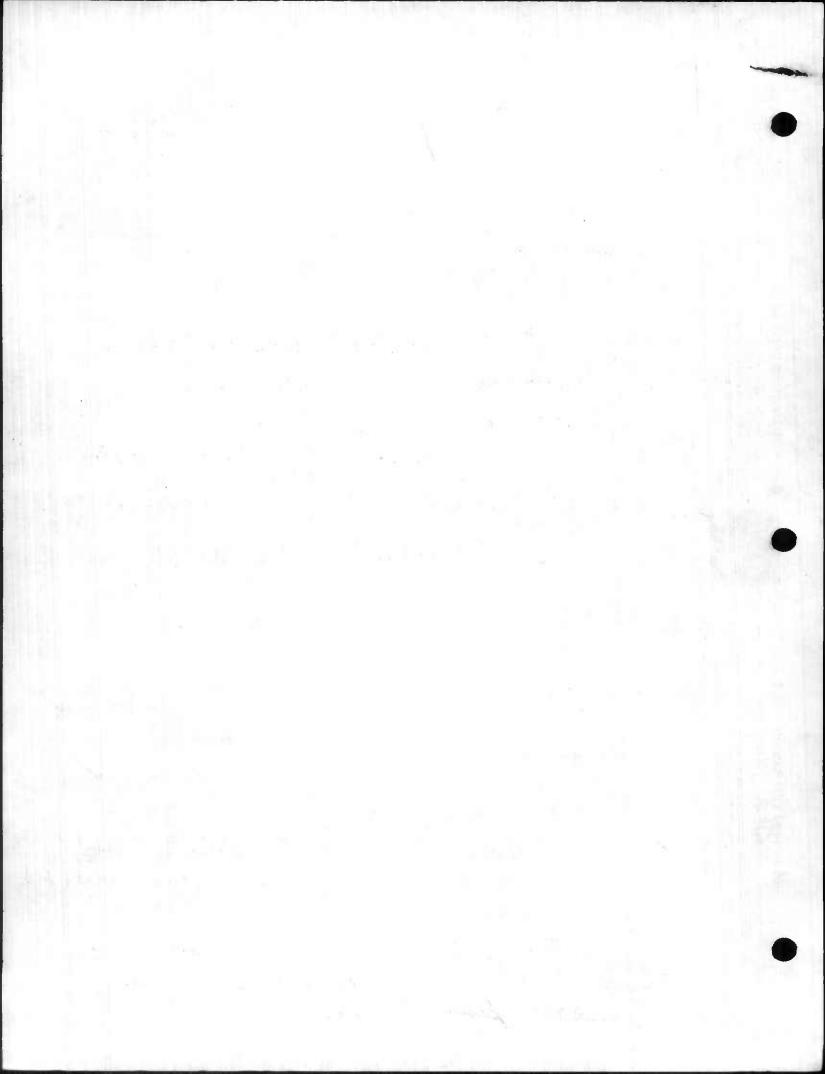
111 Penn Street, Baltimore, Maryland 21201

State Registrar

JOSEPN
31. Date filed (Month Day, Year)

JAN 20 1999

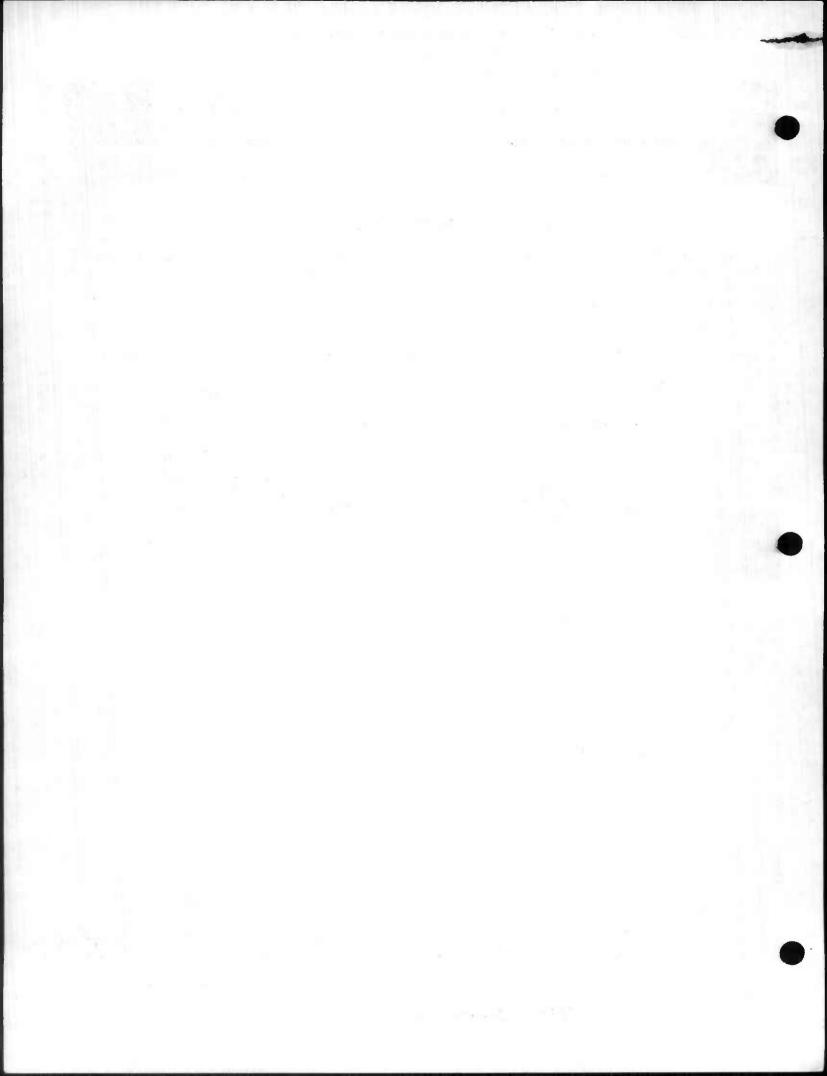
32. Registrar's Signature



	Amend	#1	7.18, 1/21/99,				Certificate			Mental Hy	/giene) (0 2	2527
	Physic		1. Decedent's Nama (First, Mic	dia, Last)						2. Data of D Month	Day	Yaar	3. Tima of Death
d	/Medi		Lileth Albert 4a. Facility Nama (If not institut					4b.	City, Town,	Januar or Location of Dea	-	-	8:35 AM
7	Exami	ner	Montgomery Vi			Rehab	ilitation					gomery	V
	Funeral Director		5. Social Sacurity Number 512-07-5504	6. Sax 1 ☐ M 2 🖾	7. Aga (In yrs. last birt	hday) If Under 1	Yaar II	Undar 24 F	Irs. 8. Data of Bi		9. Birthple Countr	ece (Steta or Foreign
	and tand		Usual Residence of Decedant 10a. Stata 10b. Cour	ty	1	Oc. City, Town	or Location					100	d. Inside City Limits
	deeth with the Meryland rms 23a or 28a-f show rmst be notified at	to	Maryland Mon	tgomery		Montg	omery Vil	1200					1 ☐ Yas 2 📉 No
	or 284	Directo	10e. Street and Number	-8			10f. Zip C				10g. Citizen of	What Country	y?
	23a		19301 Watkins	Mill Roa	d			0886			United	States	3
020	or ite	by Funeral	11. Marital Status 1 □ Navar Married 2 □ Mi 3 ☒ Widowed 4 □ Divorce	Armed 1 7 Y	Decadant Evant d Forcas? das 2⊠No , Giva or Datas:	arin U,S.	13. Was Dacedar If Yas, specify 1 ☐ Yas 2 ☑		anlc Origin? Maxicen, Pu Specify:	(Specify Yas or N arto Ricen, atc.)	o- 14. Rac Bia Specify	e - Amaricar ck, Whita, at White	
21215-0020	2 5 5	Completed	15. Decedi (Specify only high	ent's Education east grada complet	ed)	16a.	Dacedant's Usual ((Giva kind of work of lifa. DO NOT usa :	Occupatio	n ng most of i	vorking	16b. Kind of B	usiness/îndu	stry
212	d within jiene. r than "r	ошо	Elamantery/Secondary (0-12	Colleg	ge (1-4or 5+)		Sales Cle				Donortm	ont Ct	ono
P	e filed al Hygie other vant,	BeC	17. Fathar's Nama (First, Middl	a, Last)			Jares Ole		. Mothar's N	lama (First, Middle	Departm a, Maidan Sumen		.ore
lar	should be nd Mental marked o	To B	-Charles Boeh	nlein- J	ohn L.	Boehn	lein		Alie	e Looffle	r Victor	ria Al:	ice Kirby
Maryland	end end s	ľ	19a. Informant's Name/Ralatio				Mailing Addrass (5						
	Health France 17		Ruth C. Gander	/Daughte:	r		l6 Bradfo		rive,				
٥	iges 1 er of Hea or other		20a. Mathod of Disposition 1 ☐ Burial 2 ☑ Cremation		om Stata	cematar	Disposition (Nama r, cramatory or othe	ar placa)	January	17, 1999	20c. Location		
Baltimore,	permit. Pages Depertment of I important: If Ite any Injury or of once.		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Servition			Metrop	olitan Cı			phort A			/irginia eral Home/
Ba	Deperiment of the periment of		21. Signatura di Punarai Sarvi.	Licerisaa	M	01126	Rockvill						
	Physician /Medical Examiner		23a. Part1. Efficient diseasa, shock, or haart failura. Li Immediate Ceusa (Final diseasa or condition resulting in deeth)		ronary	Artery	Rockvill ot antar the mode of y Disease onsequence of):	of dying, s	such as card	liec or respiretory	errest,	C	Approximete Intervel Between Onset and Deeth
_	Pa is	iner		a b									
(09289)	ritificate be executed ng physicien and set the buriel-transit	Medicai Examiner	Sequentially list conditions, if any, leading to immadiate ceuse. Enter Undartying Causa (Disaase or injury that initiated avents rasulting in deeth) Last	c			onsequance of):					1	
Box	death certified attending of for use es	lan		d									
P.O.	t the d	by Physician/M	Part II. Other algorificant condi	lone contributing t	o death but r	not rasulting In	tha undarlying ceu	sa givan I	n Part i.		tobacco uae co Yee 2□ No		the cause of death?
ds,	S 20									24e Wee	s an autopsy	24h Warr	a autopsy findings
Records,	2 S D	Completed	Thrombocytope	nia							ormad?	avaii	iabla prior to plation of causa aath?
E B	£ 2 2	5								1 🗆	Yas 2⊠No	10	Yas 2□ No
of Vital	Physician: The this certificate ral director, per	Be	25. Was casa rafarred to medic axaminer?	Hoepital:				Other		eath (Check only			
ō	Physical direction	1: To	1 ☐ Yas 2 ☒ No 27. Manner of Daeth	1	☐ Inpatient ate of Injury	2 ER/Out		-		Homa 5 ☐ Ras	how injury occur		
ion	Attending Is death. actor: After by the funer	ation	1 ⊠Natural 5 ☐ Pand		Month, Dey Y	<i>(ear)</i> In	jury M	. Injury at Work? 1 ☐ Yes	2 🗆 No	200. 0000100	now injury occur	100	
Division	or Attendia efter death. Director: A d in by the fu	Certification:	3 ☐ Suicida 6 ☐ Coui	mined 28a. P	lace of Injury uilding, atc. (- At home, fer Specify)	m, straat, factory, o	office			(Street and Numb own, State)	per or Rural I	Pouta Number,
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Diractor: Affer this certific completely filled in by the funeral director,	edicai (I Examiner: On th		amination and	death occurred at for investigetion, in						
	To the Comp	Me	29b. Signature and title of certif	ar ()	,		29c. L	icansa nu	mber	T	29d. Data signe	d (Month, De	ay, Year)
	5		30. Nama and addrass of perso	H Jau	ML suise of deat	M (Item 23a) ([vpe Print)	30	692	2	JANUA	Ry 1	5,1999
			Gabriel A. Ber				dy Grove	Road	d, #30)5. Rocky	ille. Ma	arvlan	d 20850
			31 Date filed (Month Day Vee		2 Posistra-l-	Cignoture			, ,,,,,	- , 10010	, 110		~ 20000

Registrar

32. Registrar's Signatura B. Aparly



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JOHN JAMES CL ARK JANUARY 18, 1999 2:09 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 8ept. 20, 1919 Massachusetts If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1 XM 2 F 130-07-2059 79 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Medical Examinal must be notified at 1 Yes 2 No Director Marvland Charles La Plata 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 303 Charles Street #5 20646 USA Funeral 12. Wes Decedent Ever In U.S. Armed Forces? VDXYes 2 □ No If Yes, Give Yeer or Datas: 1942-62 14. Raca - American Indien, Bieck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yas 2 ☐ No Specify: ρλ permit. Pages 1 and 2 should be filed within 72 hours Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic and inj 3 □ Widowed 4 □ Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Draftsman Surveying 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Roland H. Clark Mary Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred R. Arnold-Stepdaughter 2390 Hwy 91, Elizabethton, TN 37643 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ **Cremation 3 ☐ Removal from State Huntt Crematory 1-19-99 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Huntt Funeral Home John P Knisley M01164 P. O. Box 156, Waldorf, MD 20604-0156 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona causa on each line. Approximate fntervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Diseasa or injury that initiated events resulting in death) Last physician er s the burial-t P.O. Box 68760. to (or are consequence of) attending for usa es Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 □ No 3 Probably 4 Unknown Records, Be Completed by 8 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? peen completion of cause of deeth? hes 25. Was case referred to medical examinar? 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, I 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Yes 2 No 1 k Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homleide Medical Certifying Physician: To the bast of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and mannar as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 29d Date signed (Month, Day, Year)

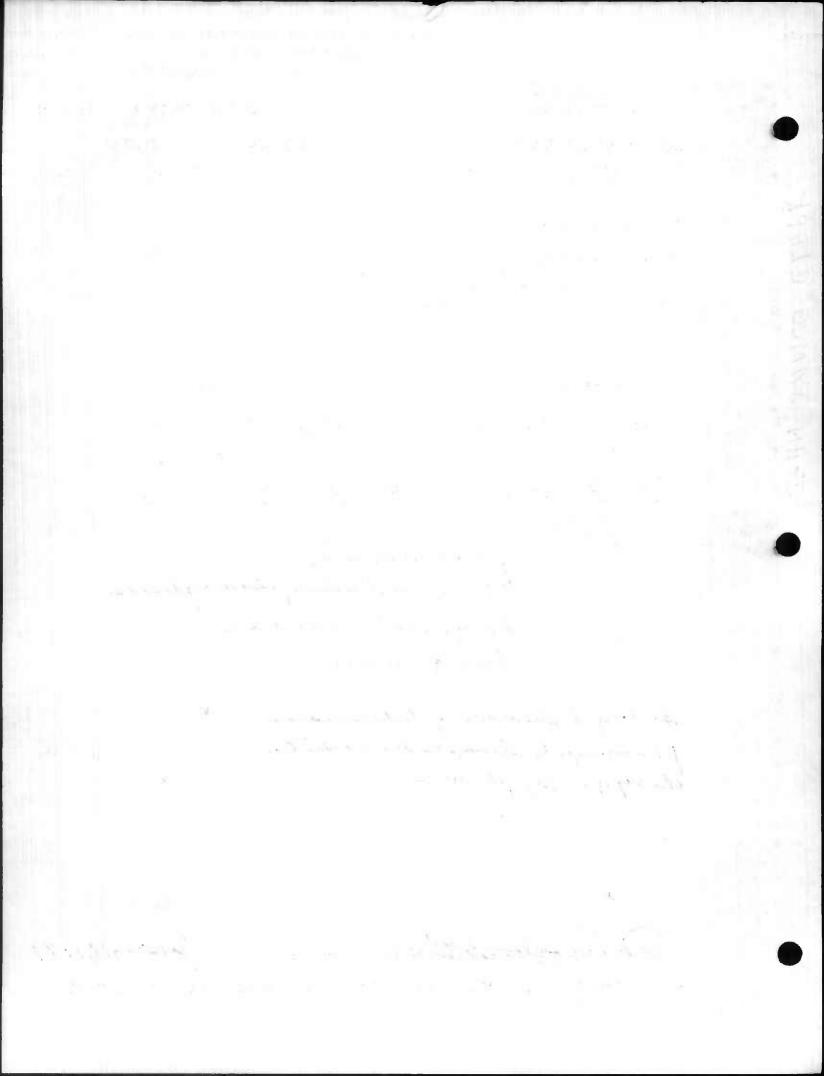
State Registrar

31. Date filed (Month, Day, Year) JAN 22 1999

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

PAUL E. PRITCHETT M.D. 118 LAGRANGE AVENUE P.O. BOX 1317 LAPLATA MD. 20646 32. Registrar's Signeture

D-08370



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1 Decedent's Neme (First Middle Last) JANUARY **Physician** 16, 1999 WALTER CHARLES COOK 9:00 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Months Hours 1 M 2 □ F 95 Yrs. 215-36-8093 Director JULY 6,1903 MARYLAND Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be nouthed at 1 ☐ Yes 2X No WESTMINSTER MD. CARROLL Director 10e, Street end Number 10f. Zip Code 10g. Citizen of What Country? 1901 RIDGE RD. 21157 USA. death v Funeral 12. Was Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Status Bleck, White, etc. should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 No Specify: p 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) DAIRY FARMER AGRICULTURE 5 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flom 27 Is marked othe any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) CHARLES COOK WIVIE ZILE 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) GARY E. COOK - SON 2233 NICODEMUS RD., WESTMINSTER, MD. 21157 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 N Buriel 2 □ Cremetion 3 □ Removel from Stete STONE CHAPEL CEMETERY1/19/99 WESTMINSTER, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failuge. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of) physician a the burial-Box 68760 8 Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of) 987 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. ğ 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records, P. by 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of ceuse of deeth? The law 2 9090 # certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 86 25. Wes cese referred to medicei 26. Place of Deeth (Check only one) 28 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes □ Inpatient 2□ ER/Outpetient 3□ DOA Bits 28e. Dete of Injury (Month, Day Year) 27. Manper of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? Neturel Athending 5 Pending 1 Yes 2 No Investigetion 2 Accident Director 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homicide b A 24 hours Diversif D Hospital 29a. Certifier (Check only 🕊 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es stated. edical 2 Medical Examiner: On the basis of examinetion end/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Within 2 å 29b. Signeture and title of a rtifie 29c. License number ersop who completed cause of deeth (Item 23e) (Type, Print)

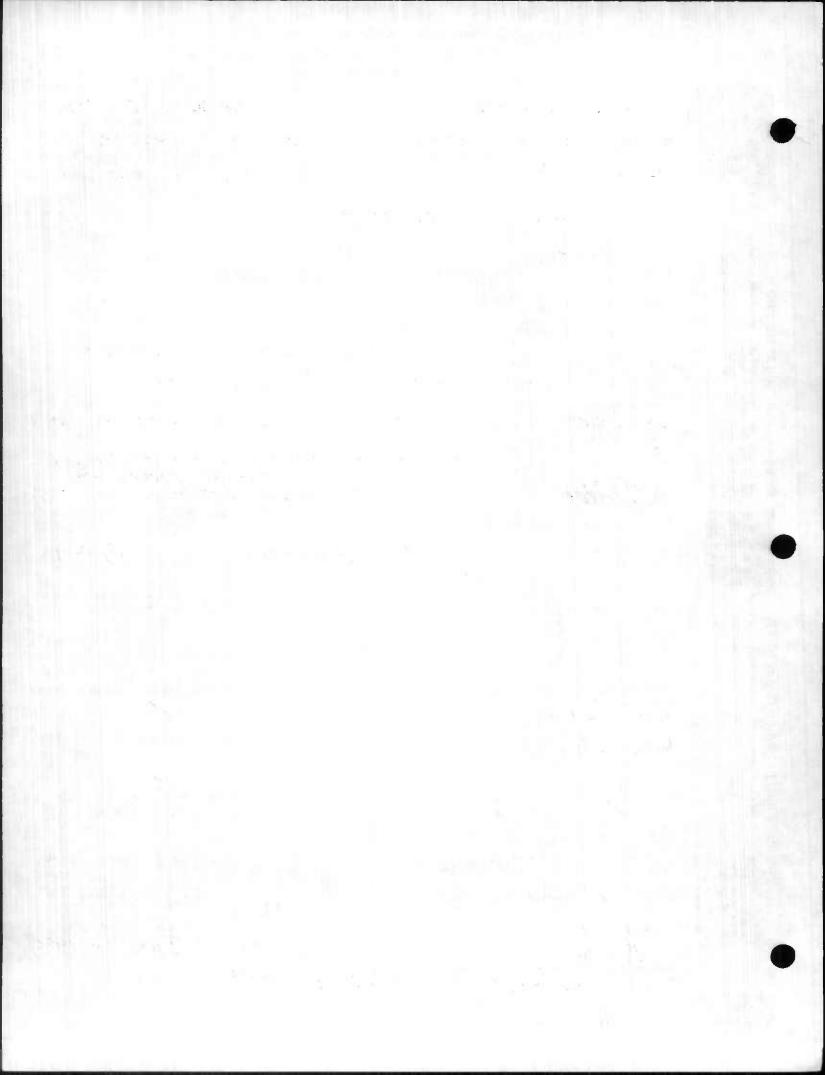
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32. Registrer's Signeture

State Registrar 31 Dete filed (Month, Day, Year)

JAN 19



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

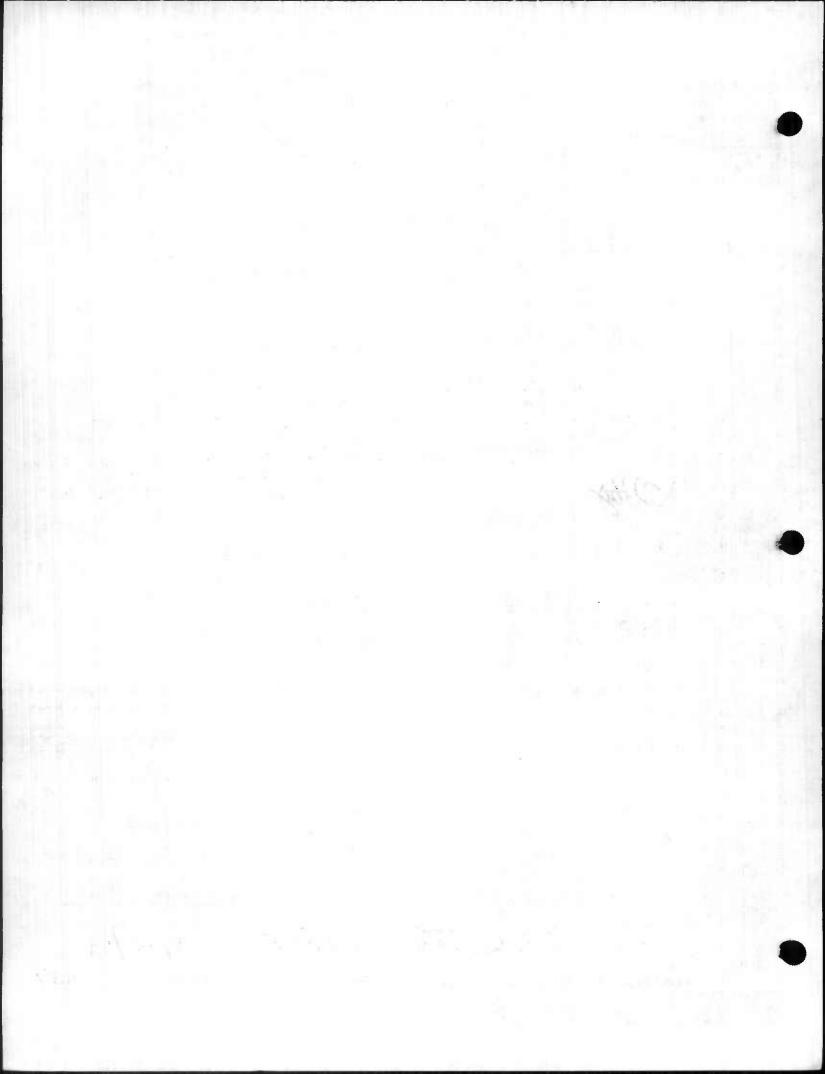
Certificate of Death 1. Decadant's Nama (First, Middle, Last) 2. Data of Death **Physician** Month Day HERBERT LEVINE CORBIN 19_ 1999 JAN. 6:30 PM. /Medical 4a. Facility Nama (If not Institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER NURSING HOME WESTMINSTER CARROLL 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Birthplaca (Stata or Foreign Country) Davs 1 M 2 □ F Director 212-16-4807 89 Yrs. 6/23/1909 MARYLAND Usual Rasidanca of Decedani the Maryland 10a State 10h County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at MD. TYP Yas 2 No Director CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò 242 GROSVENOR LANE Items 23a 21157 USA. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No 14. Raca - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Pages 1 and 2 should be filed within 72 hours efter onent of Health and Mental Hygiene.
int: If Item 27 Is marked other than "natural", or ite 1 ☐ Navar Married 2 ☐ Marriad 21215-0020 1 ☐ Yas 2 ☐No Specify: Completed by Specify: 3 Widowad 4 □ Divorced WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Spacify only highast grada completed) STATE GOVERNMENT Elementary/Secondary (0-12) College (1-4or 5+) LICENSE INSPECTOR Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Surnama) Be WILLIAM F. CORBIN, SR. ROSA MAE FRANCE other traumatic 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2: Department of Health er Important: If Item 27 is any injury or other trau NORMA JEAN PLANK -DAUGHTER 11 WHITE OAK DR., CARLISLE, PA. 17013 20b. Placa of Disposition (Nema of cemetery, cramatory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1/23/99 WESTMINSTER, MD. MEADOW BRANCH CEM. eral Service Licensee 22. Nama and Addrass of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enfar the disaasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical ARTERY **Examiner** Dua to (or es e consequença of) Examiner The law requires thet the death certificate be executed Sequentially list conditions, if any, laading to Immediata cause. Entar Undarlying Ceusa (Diseesa or Injury that Initieted events resulting in daath) Last Due to (or as a consequenca of): Box 68760, Physician/Medical Dua to (or es a consequença of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use coptribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown STROKE by Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to HYPERTENSION complation of causa of death? cartificate hes 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was case refarred to predical axaminar? 26. Piece of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. injury at Work? 28d. Dascribe how Injury occurred 1 Natural To the Hospital or Attending within 24 hours after deeth.
To the Funeral Director: Afte completely filled in by the fun 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 ☐ Sulcida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicide 117 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or invastigetion, in my opinion, deeth occurred at the time, data and place, end due to the ceuse(s) and manner stated. 29a. Cartifier Medical (Check only one) 29b. Signatora and titla of cartifian 29c. Licansa number ATTENDING 29d. Data signed (Month, Day, Year) to m PHYSICIAU 30. Name and addrass of person who complated causa of daath (Item 23a) (Type, Print) L. RUDO, ARTAUR 904 WAS HWATON ED WESTMINSTERMOZIIS MD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Rav 6/95

State

Registrar

JAN 2 0 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Daath Day **Physician** Month 14, 1999 Edgar McLaughlin 6:51 pm Causey January /Medical 4a. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST. Mary's Nursing Center Leonardtown St. Mary's if Undar 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** 1**∑**M 2□ F Days Yrs. 215-09-0360 Director April 12,1914 Maryland Usual Rasidance of Dacedeni with the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examener must be notified at Yas 2 No Maryland St. Mary's Directo California 10e. Streat and Number 10f. Zip Code 10g. Citizan of What Country? 6 45260 Cal Acres Lane 20619 items 23a USA by Funeral death 11. Maritel Status 12. Wes Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, etc. filed within 72 hours after 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2X Married 21215-0020 6 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorcad "natural", Completed Decadent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Dacadant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) end Mental Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Dulany Foods Maintenance Foreman Baltimore, Maryland 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meidan Sumama) Be Pages 1 and 2 should be Eddie Causey Mamie Schofield 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) of Health I tem 27 Pauline G. Causey/Wife 45260 Cal Acres Lane, California, MD 20619 20b. Placa of Disposition (Nema of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Data Department of Important: If it any injury or o once. 1 DBurlal 2 Demenation 3 Ramovai from Stata 1/19/99 Salisbury, MD 5 Othar (Specify) Wicomico Memorial Park 4 Donation Fungral Service License 22. Name end Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 and polications that reused had death. Do not anter the mode of dying, such as cardiac or respiratory errest, and accuracy of each line. rit1. Entar tha disaase, or com ock, or haart failura. List only Approximete Interval Between Onset end Deeth Physician mmediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events The law requires that the death certificate be saw Box 68760, Physician/Medical å P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by the page 2 should be deteched 1 ☐ Yes 2 ☐ No 3 □ Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings availabla prior to completion of causa of death? Completed 24e. Wes en autopsy performed? certificate has 2 No 1 Yes 1 ☐ Yas 2 ☐ No or Attanding Physician: Be 25. Was casa rafarrad to medical axaminer? 26. Placa of Deeth (Chack only ona) Othar: 4 Jursing Homa 5 Rasidanca 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA this 27. Mannar of Death 28c. Injury et Work? Certification: 28b. Tima of 28d. Describe how injury occurred After Division Natural 5 Panding invastigation death. 1 Yas 2 No @□ Accidant s efter death 6 Could not be datarminad 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral D Medical 29s. Certifier Medical Examination of the bast of my knowledge, death occurred at the time, date end placa, and due to the ceuse(s) end menner es statad.

Medical Examination of axamination and/or invastigation, in my opinion, death occurred et tha time, deta and placa, and due to the cause(s) (Check only onel 29b. Signature and 29d. Data signed (Month, Day, Year) 29c. Licansa number D06419 30. Name and add J. Patrick Jarboe, 24035 Three Notch Rd., Hollywood, MD 20636 h, Day, Year) 31. Date filed 32. Registrar's Signatura 1 9 1999 Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Month Physician JANUARY 1999 MAPLIC DEMALINE /Medical 4a Facility Neme (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner UNIVERSITY DEMARYLAND MEDICAL BAEDMORE CENTER 8. Dete of Birth (Month, Day. Oct. 10, 9. Birthplace (State or Foreign Country) Ohio 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Deys 1₩ 2□ F Months Hours 281-30-7922 62 Director Usuat Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. Stete 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Examinar must be notified at 1 Yas 2 No Director Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10416 Edgewood Avenue 20901 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1∆ Yes 2 □ No 1960— If Yes, Give Yeer or Detes: 1963 14. Rece - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 Never Married 2 Merried EBaitimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: Aq 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Lab Corporation filed within 7 Hygiene. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If ham 27 Ia marked other than any injury or other traumatic avent. The Important in Important in the Important in Important Elementary/Secondary (0-12) College (1-4or 5+) of America Medical Technologist 18 Mother's Neme (First Middle Maiden Sumeme) 17. Father's Neme (First, Middle, Last) e William Eldon Demaline Lillian Russell Tallman 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Leona Aletamae Demaline /wife 10416 Edgewood Avenue, Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Plece of Disposition (Nema of cematary, cremetory or other place) 20c. Location - Cify or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 1-18-99 Beltsville, Maryland Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral Services, P.A. 21. Signeture of Funerel Service Licensee 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical monsper HEMORRHAGE Examiner Due to (or es e consequence ot): certificata be axecuted burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence ot) physician as the burial-Box 68760. Physician/Medical Due to (or es a consequenca ot) attending 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the 6 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy tindings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? D000 188 1 Yes 25 No certificata or Attanding Physician: 25. Wes case referred to medicat examiner? Be 28. Plece of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Netural 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital 29e. Certifier edical 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted. 29b. Signature and title of portifia 29c. License number 29d. Date signed (Month, Day, Year) OM 1406 293 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Str. Baltimore Mayland IFE FADEYI MO S. Green 31. Dete tiled (Month, Dey, Year) 32. Registrer'a Signature JAN 1 9 1999 Registrar

JACKS PM TO NOT OF March 1995 Annie 1997 HI MARKS THE STREET

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 9:30 PM Joseph S. DiBona January 17, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village and Rehabilitation Montgomery Village Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York **Funeral** Months Davs Hours 1⊠M 2□ F 83 Nov. 6, 070-32-6755 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location r 28a-f show 10b. County 10d Inside City Limits 1 ☐ Yes 2X No Director Silver Spring Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23s or the Medical Examiner must be 15115 Interlachen Drive, #622 20906 death Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: p White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Spirit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygiera important: if Nem 27 is marked other tha any Injury or other traumatic... General Dentistry Doctor 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Salvatore DiBona Nina Notto 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20906Mafalda V. DiBona 15115 Interlachen Drive, #622, Silver Spring, MD (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Gate of Heaven Cemetery 1/20/99 Silver Spring, MD

22. Name and Address of Facility Francis J. Collins Funeral 4 □ Donation 5 ☑ Other (Specify) Entombment 21. Signature of Funeral Service Licensee 500 University Blvd.. Home, Inc. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner aspestosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es a consequence of): attending physiclan for use as the buna P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by (1 | Yes 2 PNo 3 | Probably 4 | Unknown Records, p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hes page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 D33443 banvary 15,1999 10 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

State Registrar Pollack

1999

M.O.

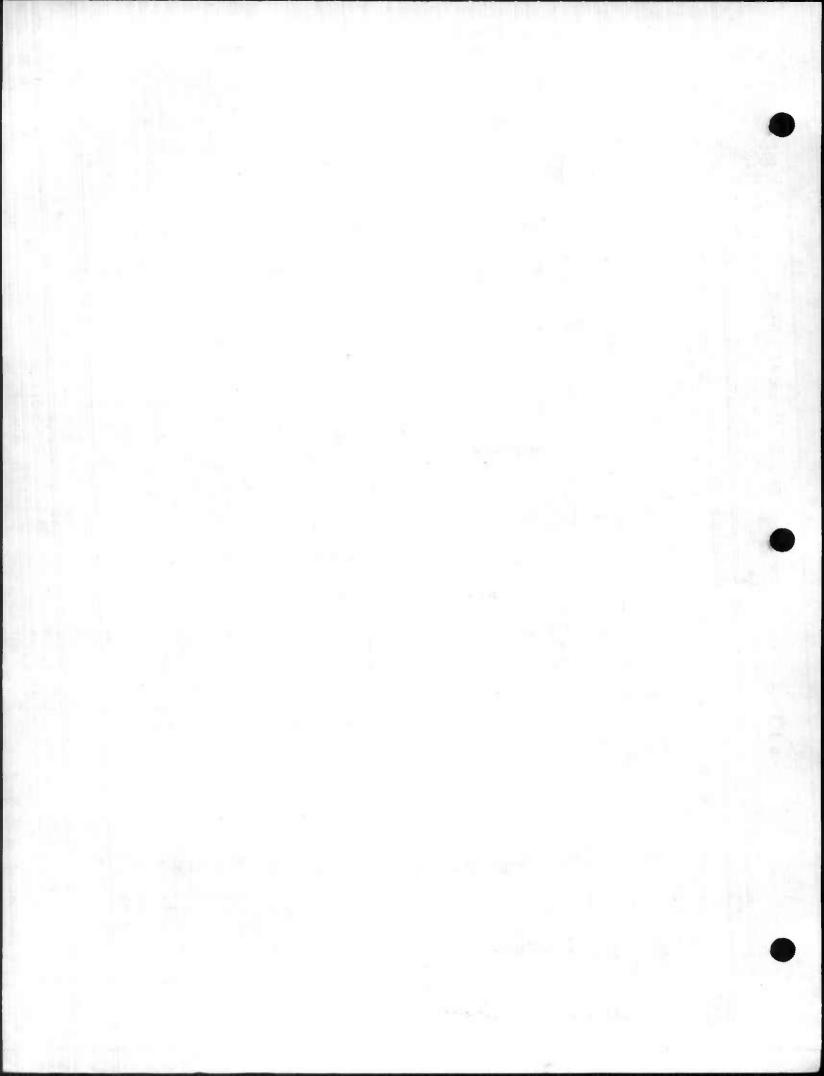
32. Registrar's Signature

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31. Dete filed (Month, Day, Year) JAN 20

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809 Viers MillRd Rockwille, Md 20851



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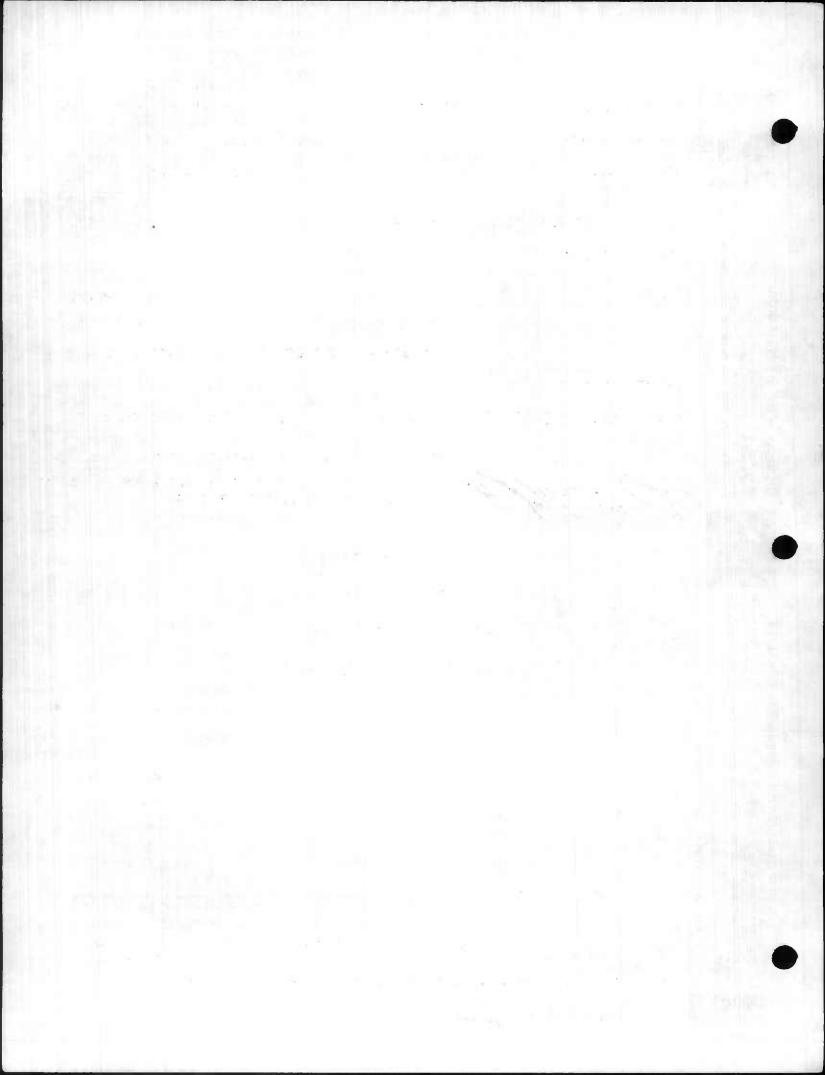
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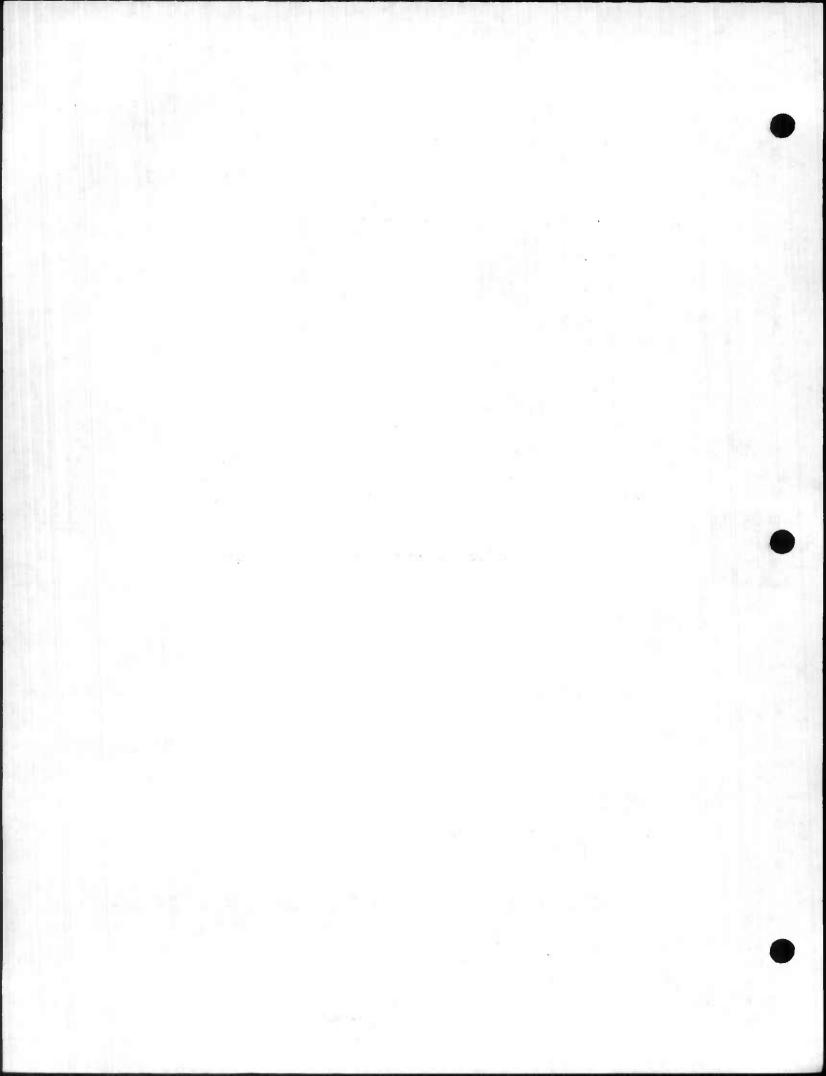
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Arline H. Dixon 9:30 AM January 19, 1999 /Medical 4a Fecility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Mariner Health Care-Silver Spring Montgomery If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours 1□M 2☑F Months 482-07-8686 80 Director Oct. 12, 1918 Iowa Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits re 23a or 28a-f show must be notified at the Maryla 1 ☐ Yas 2 No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10712 Jamaica Drive 20902 "natural", or flams 23a USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No M Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Vas 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Pan Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be illied w. Department of Heath, and Mental Hygien important: if Nem 27 is marked other th, any injury or other traumatic event, 20g. 2008. Secretary Federal Government 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be H. A. Boozell Katherine Beneke 19a. Informant's Name/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence K. Dixon (husband) 10712 Jamaica Drive, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/23/99 Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature of Funeral Service License Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one daune on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final diseasa or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 987 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? hes 1 Yas 2 No 1 ☐ Yaa 2 ☐ No Division of Vital 25. Was casa referred to medical axaminar? Be 26. Place of Death (Check only one) Other: 4 Norsing Homa 5 Residence 8 Other (Specify) P 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Beath 28a. Data of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation or Attending after death.

Director: After death. 1 Yas 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directi completely filled in by 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital of within 24 hours a To the Funeral D 29a, Certifier Medical 1 🕒 Cortifying Physician: To the best of my knowledge, death occurred et the time, data and place, and dua to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number DO9834 D 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) FARRAGUT AUE KENISINGTON, MIS ROSENBAUM 3720 2089 31. Data filed (Month, Day, Year) 32. Registrar'a Signatura State **JAN 22** Registrar

DHMH 16 Rav 6/95



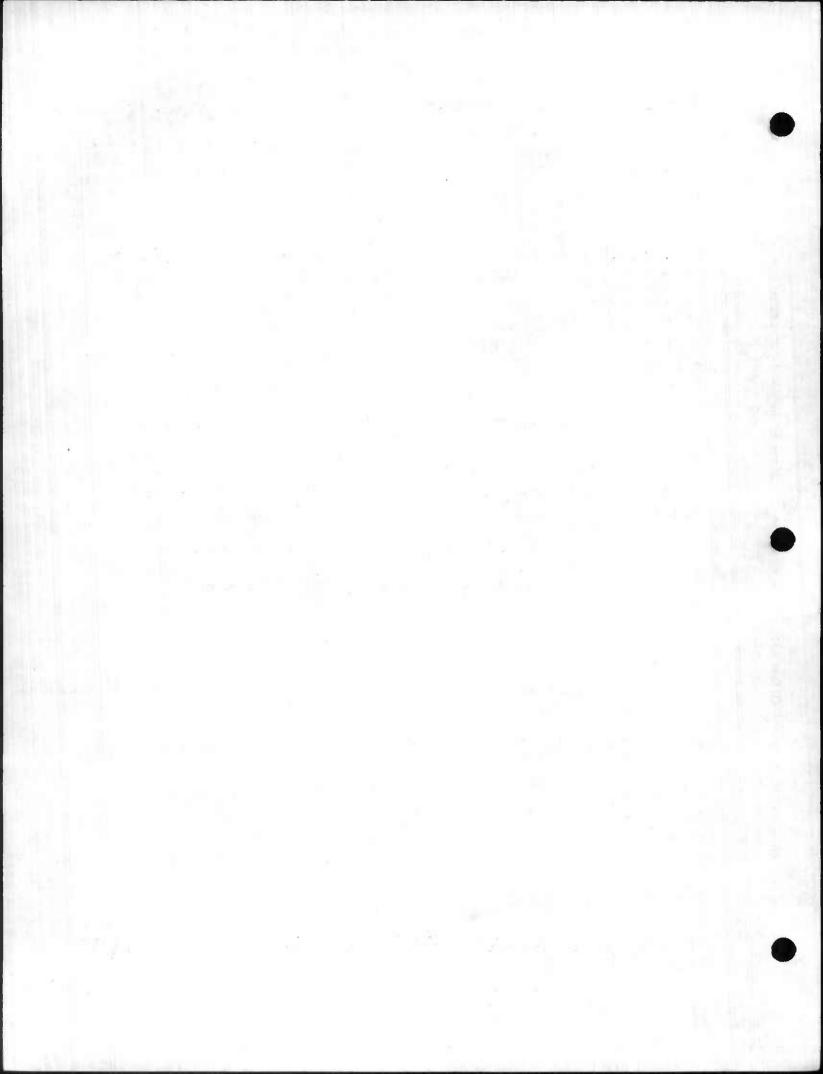
State of Maryland / Department of Health and Mental Hygiene

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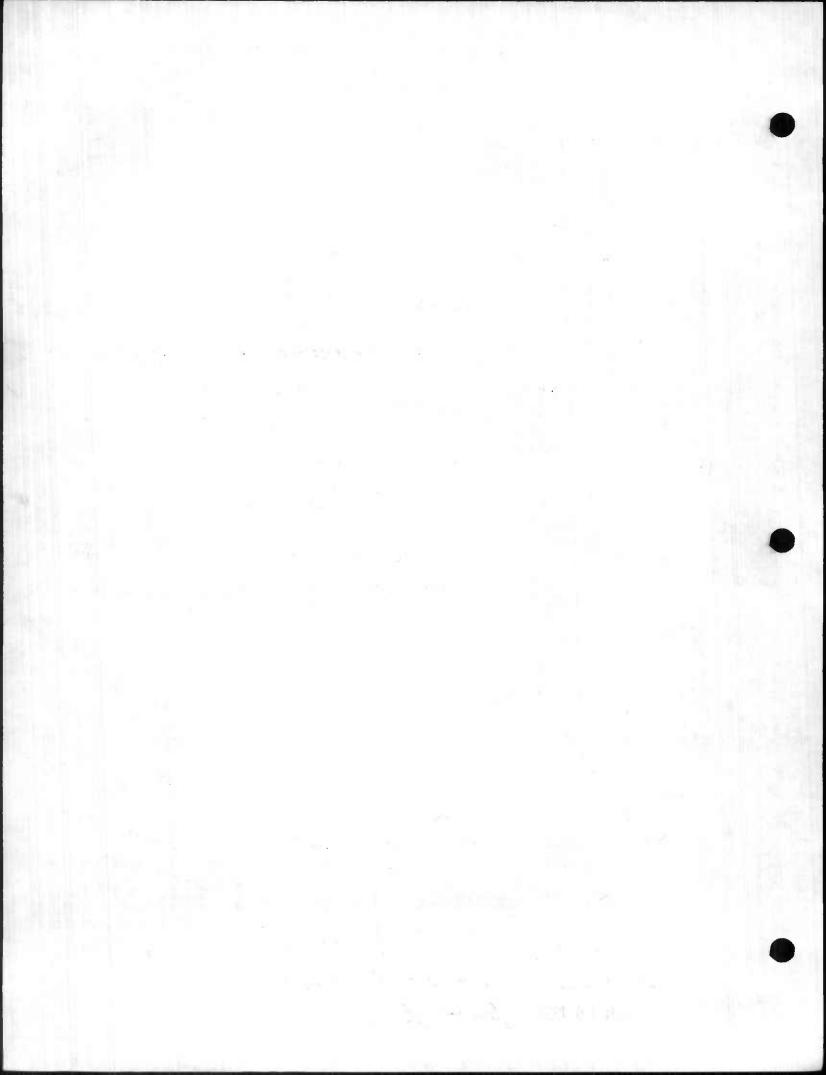
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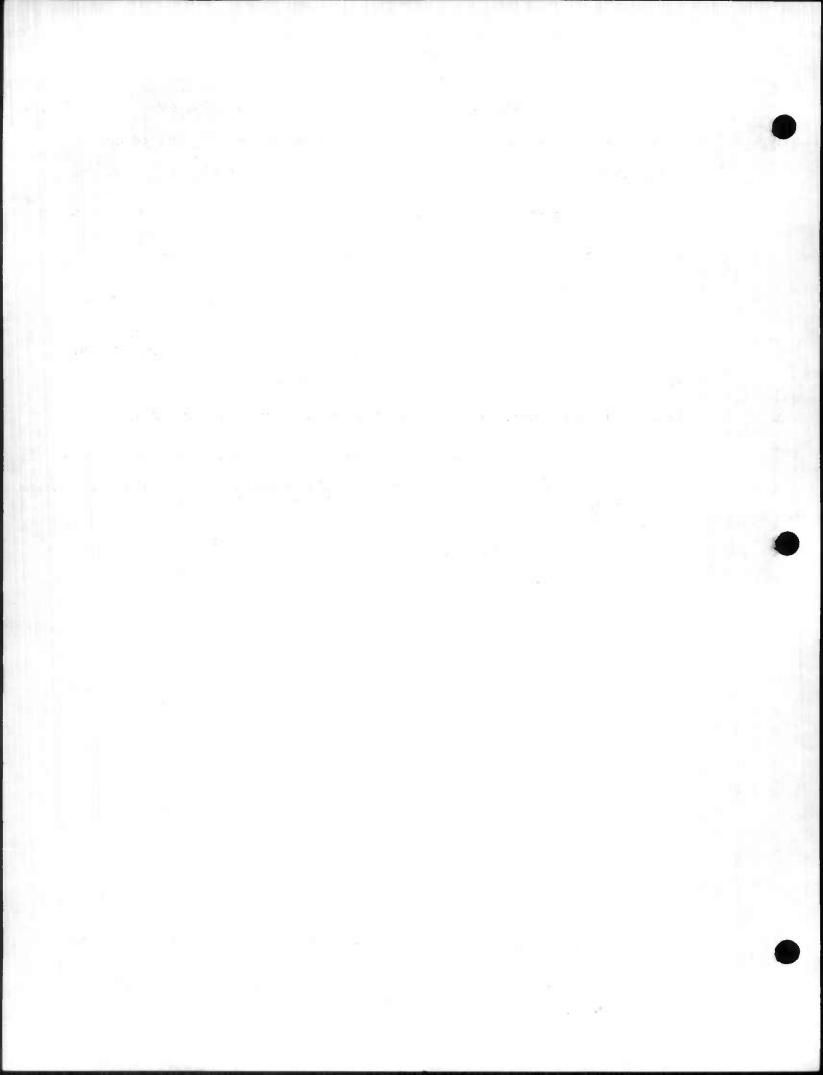
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			State of N		Certificate of			g. No. 99	02539
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	Examiner	4a Facility Neme (If not institu	ution, give street and number	or)		4b. City, Town, or Lo	cation of Death	4c. County of I	Death
			Adventist Hos	spital			ma Park	Mont	gomery
ı	Funeral Director	5. Social Security Number 209–18–2860	6. Sex 1 M 2 □ F	Age (In yrs. last birtl	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, Oct. 6,	Year)	Birthplace (State or Foreign Country) ennsylvania
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	of the one	MD Mo	ntgomery	Silve	er Spring				1 ☐ Yes 2 ☒ No
	or 28a-4 s be notified Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	t Country?
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Maryland 21215-0020	72 hours after death vertures, or there 23 dical Examiner must dical Examiner must atted by Funeral	11. Meritel Status 1 □ Never Married 2 ☑ Never Married 2 ☑ Never Married 2 ☑ Never Married 1 □ Divor	If Yes, Give	s?	13. Wes Decedent of H If Yes, specify Cubi	tispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indien, White, etc. White
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	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	a	CARDI	AC ARRHY	AIMHT			MINUTES
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68760,	e be sician e buri	Cause (Disease or injury that initieted events	С.	Due to for se s or	occanos of:				
68	= - - - - - - - - - -	resulting in death) Last		Due to (or as a co	msequence or):				
Box	Seath certific attending p of for use es		d						
	death e atten ed for u	Part II. Other significant cond	fitions contributing to death	but not resulting in	the underlying reuse give	en in Part I	23h Did to	bacco usa contril	bute to the cause of death?
P.0	by the	Takii. Oliof eigimean con		out not resouring an	and anothing couse give	on all raints.	1 TY	11	□ Probably 4 □ Unknown
ŝ	5 Pg 8								
orc	v requires been sign should be leted by						24a. Was er perform		4b. Were autopsy findings available prior to completion of cause
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	The Late he page	/					1 ☐ Ye	s 2000	1 ☐ Yes 2 ☑ No
Vital	Slan: Sertific Sctor	25. Was case referred to med examiner?			la	26. Place of Deetl	(Check only on	9)	
of	his his	1 Yes 2 No	Hospitel: 1 Inpa		patient 3 DOA Oth	4 Inursing Ho		nce 6 Other (Specify)
	aling Ph h. After th funeral	27. Manner of Deeth 1 Neturel 5 ☐ Per			jury Wor		28d. Describe ho	w injury occurred	
Sic	Attending or death. •ctor: After by the fune lification	E [] /10010011	estigation and be asset Disease to			Yes 2 No	00/ 1 10 10-		0 10 11
	*2 5 C T	4 ☐ Hornicide det	armined 200. Flace of I	njury - At home, tan etc. (Specify)	m, street, factory, office		City or Town	, State)	or Rural Route Number,
	Filled C	29e. Certifier Certif	hine Ohusialan. To the hor	l al mulanuladan	double annumed at the time				
	To the Hospital or Attance within 24 hours effected to the Funeral Director: completely filled in by the Medical Certifical	(Check only 2 Medicone)	fying Physician: To the bes cal Examiner: On the basis and manner:	of examination and	or investigation, in my o	ppinion, death occurr	ed et the time, de	ete and plece, and	due to the cause(s)
	withiu To th	29b. Signature and title of car	HIGH AR	NOLD GILE	VY MD 29c. Licens	se number	25	d. Date signed (A	fonth, Day, Year)
	ioti	1 Umal	12 Lun	MD	DI	5790		1/1:	8 99
		30. Name and address of pers	on who completed cause of	death (Item 23a) (1	Type, Print)				1
					PILVER SAR	ING, MD	20901		
	State Registrar	31. Dete filed (Month, Day, Ye JAN 1	ar) 32. Regis	itrar's Signeture	9 100	,			
	registral	01111 1		_	· BOOK	2/			



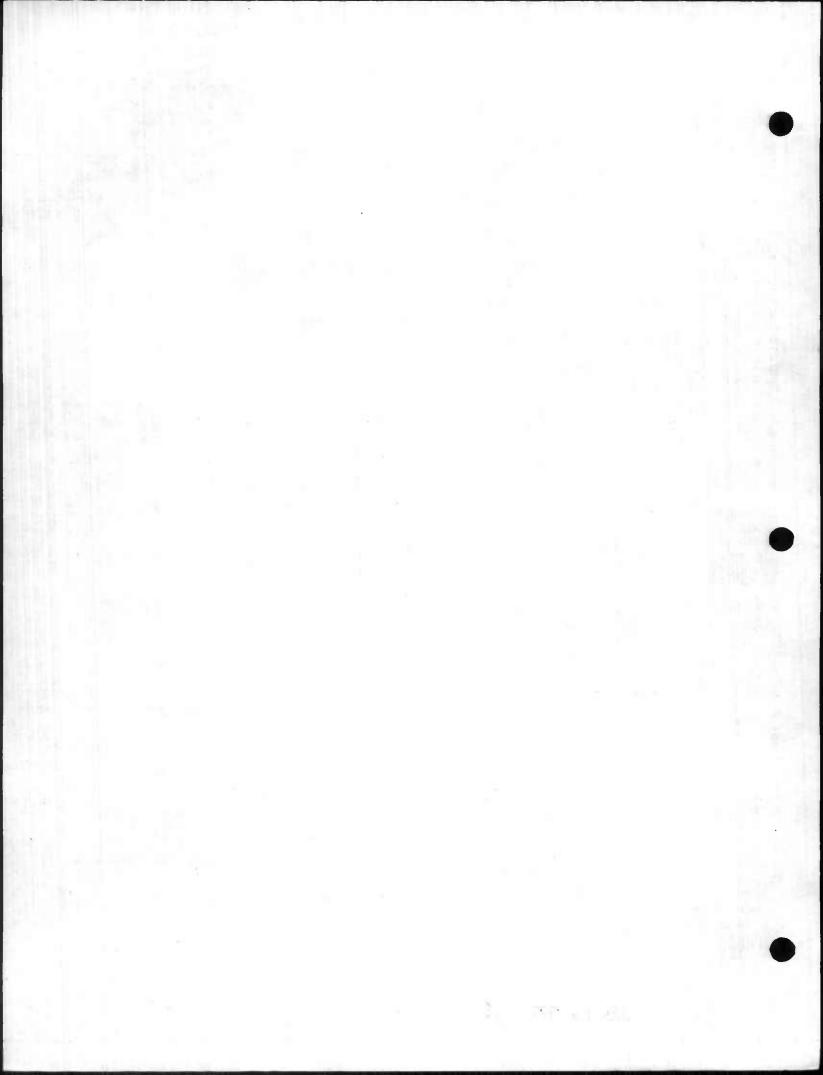
State of Maryland / Department of Health and Mental Hygiene 0 0 251, 0

						Ce	rtificat	e of	Death		Reg.	No.	U	- J	4 U
			1. Decedent's Neme (First, Middle, L	ast)							te of Deeth		Vana	3. Tim	e of Death
	Physic /Medi		Maude R.	Duncar	1					Jan	onth	1999	Yeer	6:0!	5 p.m.
	Exami		4e. Fecility Neme (If not institution, g	ive street end number)				4b. City, Town	, or Location	of Deeth	4c. County	of Deeth		
			Manor Care Nursi	ng Home					Chevy (Montg	omery		
	Funerai Director		5. Social Security Number 6. 218-30-3150 Usuel Residence of Decedent	Sex 7. A 1□M 2⊠F 9.		est birthday, Yrs.	Months Months	1 Year Deys		Hrs. 8. De Min. (M Ju.)	te of Birth onth, Day, Ye Ly 18, I	904	9. Birthple Counti Mary I	aca (Ste ry) and	te or Foreign
	Maryland H show	tor	10e. Stete 10b. County MD Montgom	ery	1	, Town or L							10		e City Limits
	h with the 3e or 28s	Funeral Director	10e. Street end Number 4007 Byrd Road				10f. Zip					Citizen of	Whet Counti	ry?	
	within 72 hours after deeth with the Maryland liene. 'than "naturel", or Hems 23e or 28e-f show The Medical Examiner must be notified at	by	11. Maritel Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 Hryes, Give Year or Detes:	?		Was Deced If Yes, spec	cify Cub	tispenic Originan, Mexican, F	n? (Specify Y Puerto Rican,	es or No- etc.)	Blee	e - America ck, White, e y: Whit	etc.	1,
	72 ho	Completed	15. Decedent's I			16e. Deca	dent's Usua	el Occup	petion during most o	funding	16b	. Kind of B	usiness/Indu	ustry	
	ithin le.	npie	(Specify only highest g Elementery/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT u	se retire	d)	i working			d & L		-
		Con	12			Sales	Lady					•	nent S	tore	e
	should be filed nd Mental Hygi marked other imatic event, I	Be	17. Fether's Neme (First, Middle, Las Unknown	t)					18. Mother's Unknow		, Middle, Mei	den Sumen	ne)		
		To	19e. Informant's Name/Relationship Wallace Thompson		phew	19b. Melli	ing Address Byrd	(Street	end Number o	or Rurel Rout	e Number, Co	ty or Town, 20895	Stete, Zip (Code)	
	a f He		20e. Method of Disposition 1 ☑ Burlal 2 ☐ Cremetion 3		Ce	ece of Disponentery, cre	matory or o	ther ple		1/18			City or Tow		
	permit. Pege Depertment o Important: If any Injury or once.	74	4 □ Donetion 5 □ Other (Spec 21. Signature of Funeral Service Lice		000	2	2. Neme en	nd Addre	ess of Fecility					-	
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	daati he att	Physician/	Pert II. Other significent conditions	contributing to death t	out not resu	Iting in the u	ınderlying c	ause giv	ven in Pert I.	2	3b. Did tobe	co use co	ntribute to t	the cau	se of deeth?
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	tal or Att	Certification:	3 SuicIde 6 Could not determined	28e. Placa of in	jury - At hor tc. (Specify)	me, ferm, st	reet, factory	y, offica		28f. Lo	cation (Stree ty or Town, S	t end Numb tate)	per or Rurel	Route N	lum <i>ber</i> ,
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	12		> Trinhoi		death dres	02-1/7		5101	1.5		Jar	uary	17, 1	999	
			30. Name end address of person who Ellen Pinholt, M					e Sı	ıite 1∩	45. CF	evv Ci	iase.	MD 20	815	
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			,	Cenifical	e of	Death		Re	g. No.	0	- C - 1 - 1
	1. Decedent's Neme (First, Middle, La	est)	HT. P.					te of Deat	h Day	Year	3. Time of Dea
hysician /Medical	Helen G.	Eng	lish					nuar	y 12,	1999	4:02 I
xaminer	4e Fecility Neme (if not institution, given	re street and number)				4b. City, Tow	m, or Location	of Death	4c. County	of Death	
	Althea Woodland	Nursing Ho	me				r Sprin	g	Mont	gomer	у
neral ector			(In <i>yrs. last birtl</i>)8 Y	mday) If Under Months	1 Year Days	Hours	Min. (Mo	te of Birth onth, Day, 20,	Year) 1900	Coun	lace (State or Fo try) ylvania
	Usuei Residence of Decedent										
H .	10a. Stete 10b. County		Oc. City, Town							1	0d. Inside City Li
cto diffe	Maryland Montgon	nery	Silver	Spring							1 Yes 2
ust be notified ral Director	100. Street and Number 1000 Daleview Dri	ve		10f. Zig	Code 901			10	Og. Citizen of United of A	What Coun Stat meric	es
Examiner m by Funer	11. Maritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 🔯 No If Yes, Give Year or Detes:				lispanic Orig an, Mexican, Specify:	in? (Specify Ye Puerto Rican,	etc.)	Ble	e - Americ ck, White, o	etc.
c, the Medical	15. Decedent's E		16a. I	Decedent's Usu	al Occup	pation	of warding		16b. Kind of B		
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Be	17. Father's Name (First, Middle, Last)				18. Mother	's Neme (First,	Middle, N	faiden Suman	ne)	
To de	James W. Geery					Leah	Towns1	2 у			
	19e. Informent's Name/Reletionship (Type, Print)	19b.	Meiling Address	s (Street	and Number	r or Rural Route	Number,	City or Town,	State, Zip	Code)
E .	James A. English	/Son	612	20 85th	Pla	ce, Ne	w Carro	ollto	n, Mar	yland	20784
ary or oth	20e. Method of Disposition ¼ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specie			Disposition (Na crematory or C Cemeter		ce)	Janua 118,	ary	Media		wn, Stete
as the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	6. Lecrt	ue to (or as a co	ensequence of):						1	
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or use a	resulting in deeth) Last	d			cause giv	ren in Pert I.	2	3b. Did to		entributa to	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:55 PM JANUARY 16 1999 ANNA E. ETHRIDGE /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner LA PLATA CHARLES CIVISTA MEDICAL CENTER if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, June 3 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 21 F 77 Yrs. June 247-03-5151 Virginia Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at NE Yes 2□No Director Maryland | Charles Waldorf the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with USA 48 Tadcaster Circle 20602 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours efter 1 Yes 2 No If Yes, Give Yeer or Dates: 1 □ Never Married 2 □ Married "naturel", or i Baltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: by 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. US Government Telephone Operator 12 other permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If fleen 27 is marked othy any finity or other treumatic event pates. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Baqwell Henderson Arthur N. Henderson 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3592 Palmetto Court Waldorf, MD 20602 Barbara E. Snyder (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Cem 1-19-99 Waldorf, MD 4 Donation 5 Other (Specify) 21. Signature of Fundral Serviced loans 22. Name and Address of Facility M00173 J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695 Enter the disease, or complications that ceuse, or heart failure. List only one cause on each complications that caused the death. Do no Approximate Intervel Between Druet and Death **Physician** /Medical immediate Cause (Final disease or condition resulting In deeth) Examiner Physician/Medicai Examiner law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a cons X physician e the burial-Box 68760, 88 950 ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o signed by 1 Yes 2 No 3 Probably 4 Unknown ۵ Division of Vital Records, by 8 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed should peed: completion of cause of death? hes The 1 ☐ Yes 🏖 No 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Inpatient 2 ER/Outpatient 3 □ DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 24 hours efter deeth. Funeral Director: After I 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifie 1 🛣 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as stated. edical (Check only one) completely 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete end plece, and due to the cause(s) and manner steted. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month)

ed ceuse of death (Item 23a) (Type, Print)

istrer's Signeture

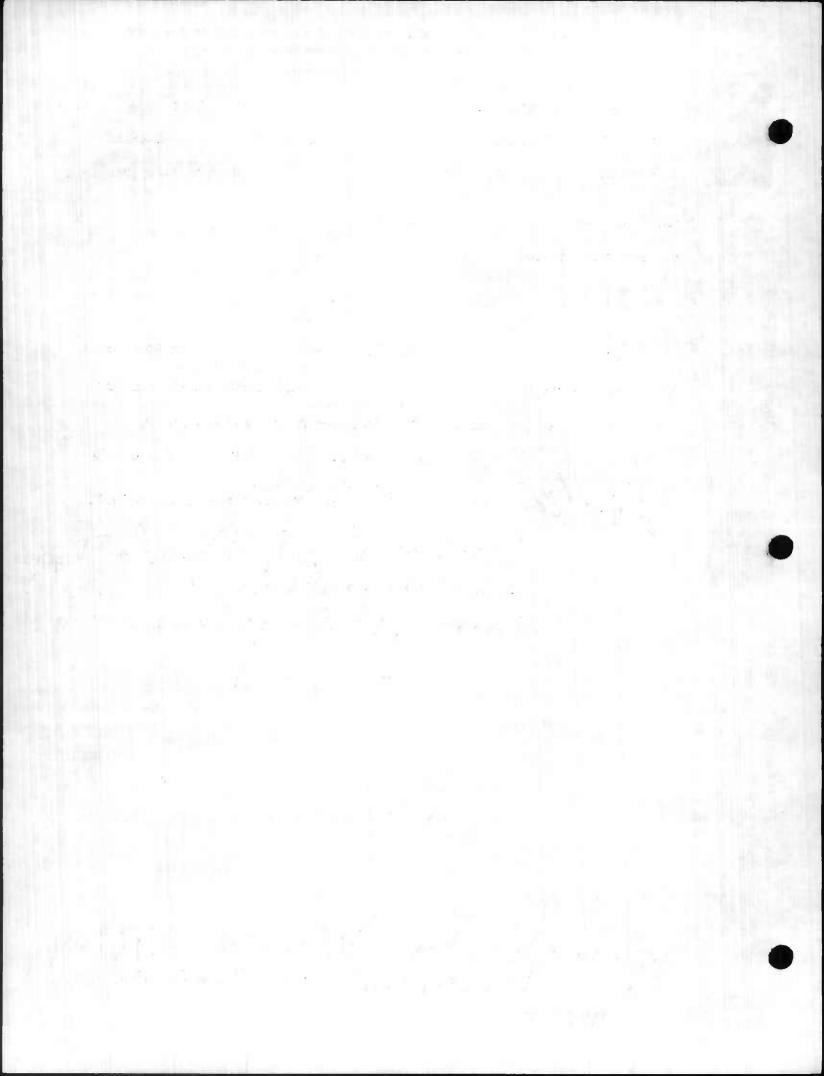
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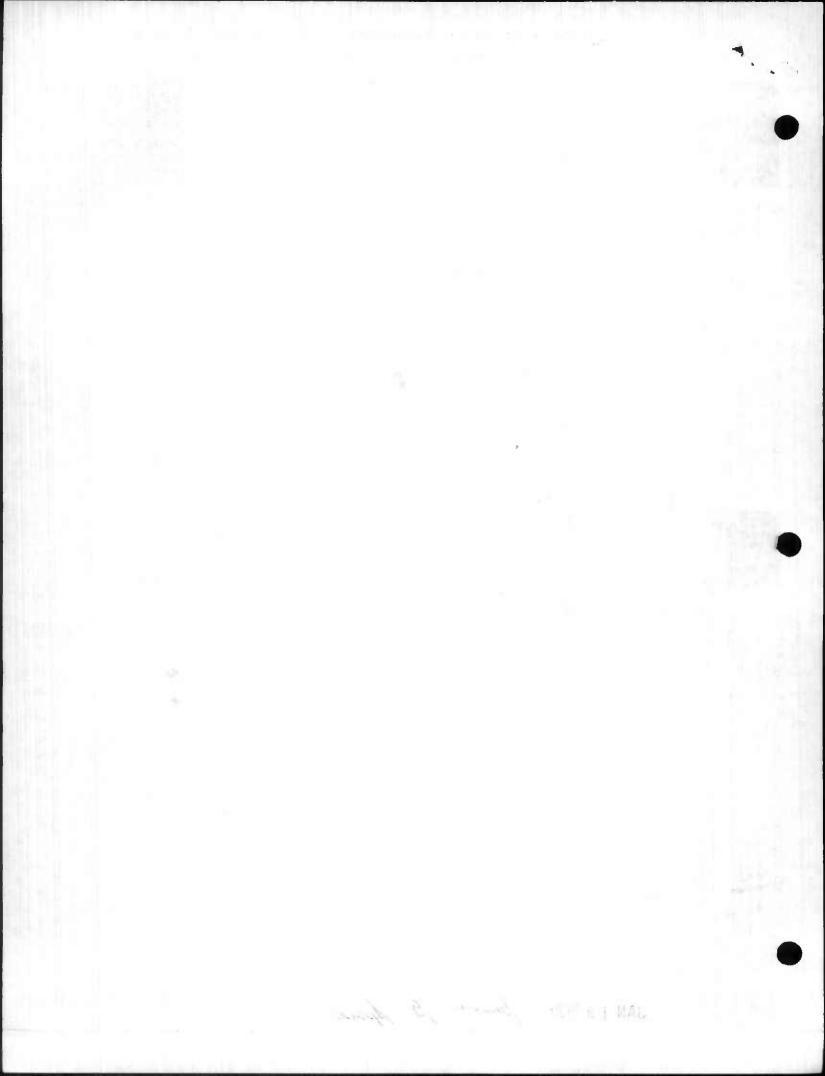


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMENDED: # 8 State of Maryland / Department of Health and Mental Hygiene DOB 12/25/18 WCHD BBK 1 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month 1/14/ 1999 1:00 PM WILLIAM VINCENT /Medical 4a. Facility Name (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner At Home- 20916 Bivalve Wharf Road Bivalve, Md. Wicomico Dete of Birth (Magth, Day, Year) 9. Birthplaca (Stata or Foreign Cainty) 12/24/1918 Washington, DC If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) **Funeral** 1MM 2□ F Months Days Hours 229-03-6372 80 Vre Director Usual Residence of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Wicomico 1 Yes 2 No Bivalve 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5 20916 Bivalve Wharf Road 238 21814 U.S.A. death Funeral 12. Was Decedent Evar In U.S. Armed Forces? WW 2 Herns 14. Rece - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or their any Injury or other traumatic event, the Medical Example. Black, White, etc. In the second of 1 Never Married 2 TM arried Baltimore, Maryland 21215-0020 by Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Electrician Electrica1 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surneme) Be Emory David Erwin Mildred Petrolla 19e. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Gisele Erwin, Wife P.O. Box 65, Bivalve, Md. 21814 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory 1/14 Salisbury, Md. 21. Signature of Funaral Service Licensea 22. Name and Address of Facility
Messick Funeral Home, P.O. Box 61 MOO-417 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, or haart feilure. List only one ceuse on each line. Bivalve, Maryland 21814 Approximate Intervei Betw Onset and Deeth Physician /Medical Immediate Ceuse (Final mont disease or condition resulting in deeth) Examiner Physician/Medical Examiner physician and the buriel-transit be axecuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last 19000 Box 68760. 88 usa signed by the a d be detached f Part II. Other algnificant conditions contributing to death but not resulting in the underlying/cause given/in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? Dleed 8 1 Yes 2 No 3 Probably 4 Unknown rsb Bussewar by Records, should l 24b. Were autopsy findings evailable prior to complation of causa of death? 24a. Was an autopsy performed? Completed The law page 2 certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Piece of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending efter death.

Director: Aff 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 2 4 Homicide filled in 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 26 29b. Signeture end tij 29d. Date signed (Month, Day, Year) 540 KNEENDE DRIVE 80 31. Date filed (Month, Day, Year)

JAN 19 1999 32 Registrer's Signature State Registrar

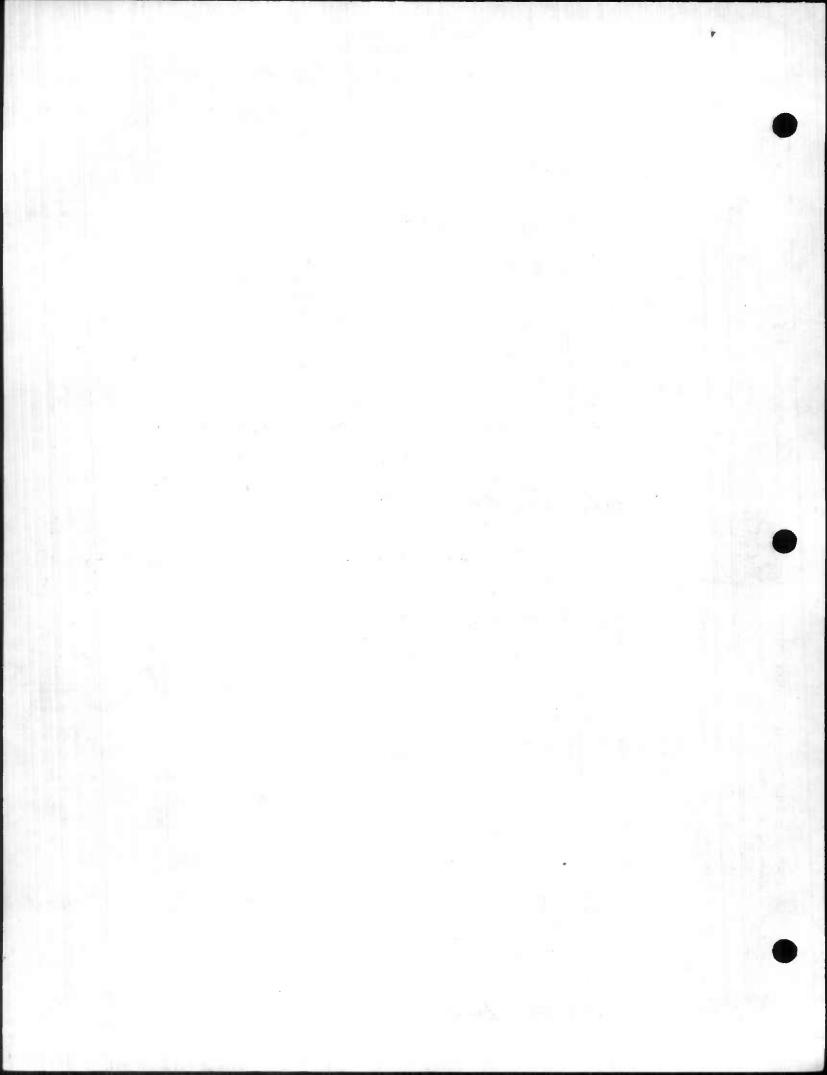


State of Maryland / Department of Health and Mental Hygiene

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	4a Facility Name ((If not institutio	n, give street a	nd number)				41	. City, Town, or	r Location of Deat	h 4c. County	of Death	
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	5. Social Security N	Number	6. Sex		ge (In yrs. le	st birthday)	If Under	1 Year Days	If Under 24 Hr. Hours Mir		th Veerl	9. Birthpla	ice (Stete or Foreig
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00	17. Father's Name	(First, Middle,	Last)						18. Mother's Ne	eme (First, Middle	, Maiden Suman	ne)	
	Paul L.	Fickin	nger						Bern	ice M. H	arris		
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DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death FOUND 1. Decedent's Name (First, Middle, Last) 2. Deta of Death Dey 1615 MATTHEW O. FLYNN JANUARY 12, 1999 FOUND 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death FORT WASHINGTON 11064 LIVINGSTON PRINCE GEORGES ROAD If Undar 24 Hrs. If Under 1 Yaar 8. Date of Birth (Month, Day, Year) Sep. 21, 1964 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Months Devs Hours MISSouri Yrs 34 493-72-6922 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Virginia Fairfax Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22181 USA 9640 Masterworks Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yea or No-If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - Amarlcen Indian, 11. Marital Status Black, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Caucasian 3 Widowad 4 Divorced Yaar or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12 N/A Unemployed 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Surneme) Mary Joyce O'Neill John J. Flynn 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John J. Flynn/Father 9640 Masterworks Drive, Vienna, Va. 22181 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta Data 20a. Method of Disposition Burlel 2 Cremation 3 Ramoval from Stata 1/18/99 St. Louis, Missouri Calvary Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MONEY & KING VIENNA FUNERAL HOME, INC. 21. Signature of Funeral Servica Licente 171W. Maple Ave., Vienna, Va. 22180 23a. Part1. Enter the disease, or complication, that causad the death. Do not entar tha moda of dying, such as cardiac or raspiratory arrest shock, or haart failure. List only one cause on each line. Approximata Interval Between Onaat end Death Immediata Causa (Final GUNSHOT WOUND disease or condition resulting in death) Due to (or as a consequanca of) Sequentially list conditions, if any, laading to immadiate ceuse. Enter Underlying Ceusa (Disaasa or injury that initiatad events resulting in death) Lest Dua to (or as a consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 1 Yee SCHIZOPHRENIA 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Was an autopsy 2 No 1 Yes 1 Yes 2 No 25. Was cese referred to medical 26. Placa of Daath (Check only ona) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding investigation 1615 FOUND 1 Yes 2 No SUBJECT SHOT SEVE 281. Location (Straat and Number or Rural Route Number City or Town, State) 01-12-99 FOUND 2 Accidant 6 Could not be determined Suicide 4 Homicida 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

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Funeral

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permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If Item 27 is marked other any large. But But Injury or other traumatic event Pates.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner 98 2 Completed Be 10 Certification:

The law requires that the death certificete be executed physicien and s the burial-trensit attending for use es signed by the a should t iis certificate hes I director, page 2 s Attending Physician: s aftar death.

I Director: Aftar this od in by the funaral di this

Records, P.O. Box 68760.

Division of Vital 6 To the Hospital o within 24 hours af To the Funeral DI completely filled in

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27. Mannar of Death

29a. Certifier

29b. Signa

(Check only

OFFICE

11064 HVINGSTON RO, FT. WASHINGTN

Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

DRIVE, CHEVERLY, MARYLAND

of death (Item, Z3a) (Type, Print)

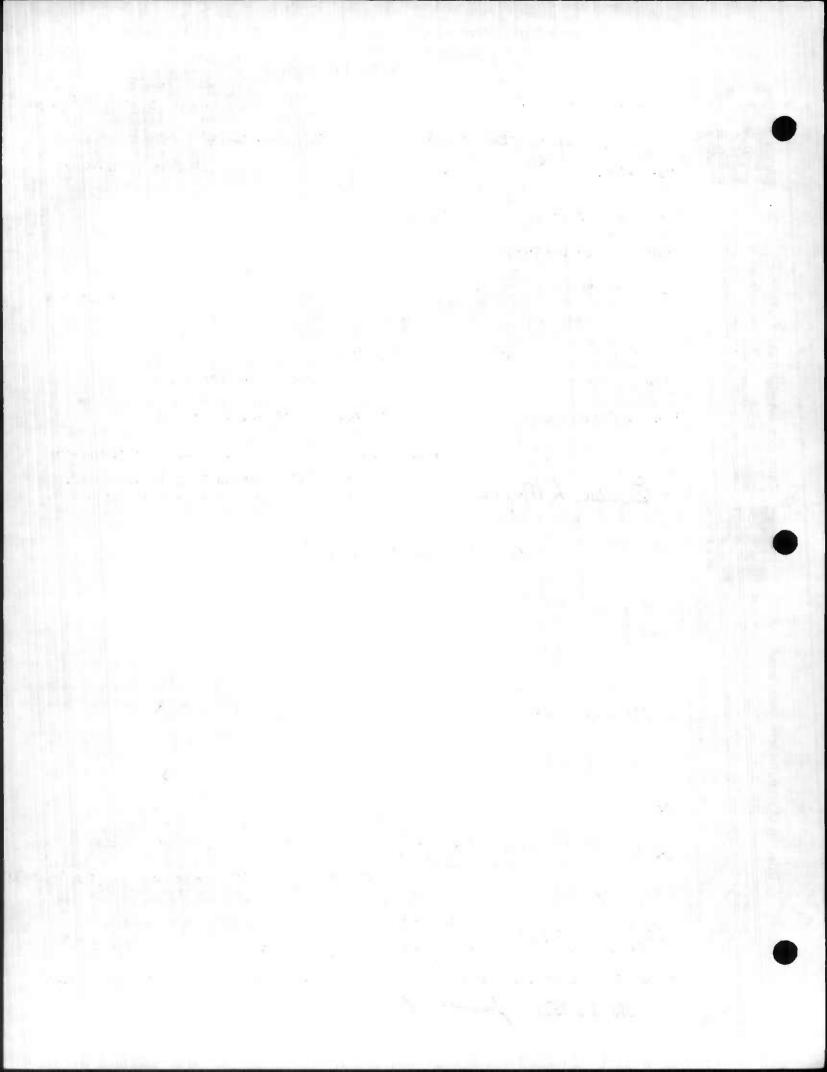
MARIO F_ GOLLE JA MY 3011 31. Data filad (Month, Day, Year) 1999

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HOSPITAL 32. Registrar's Signature

State Registrar

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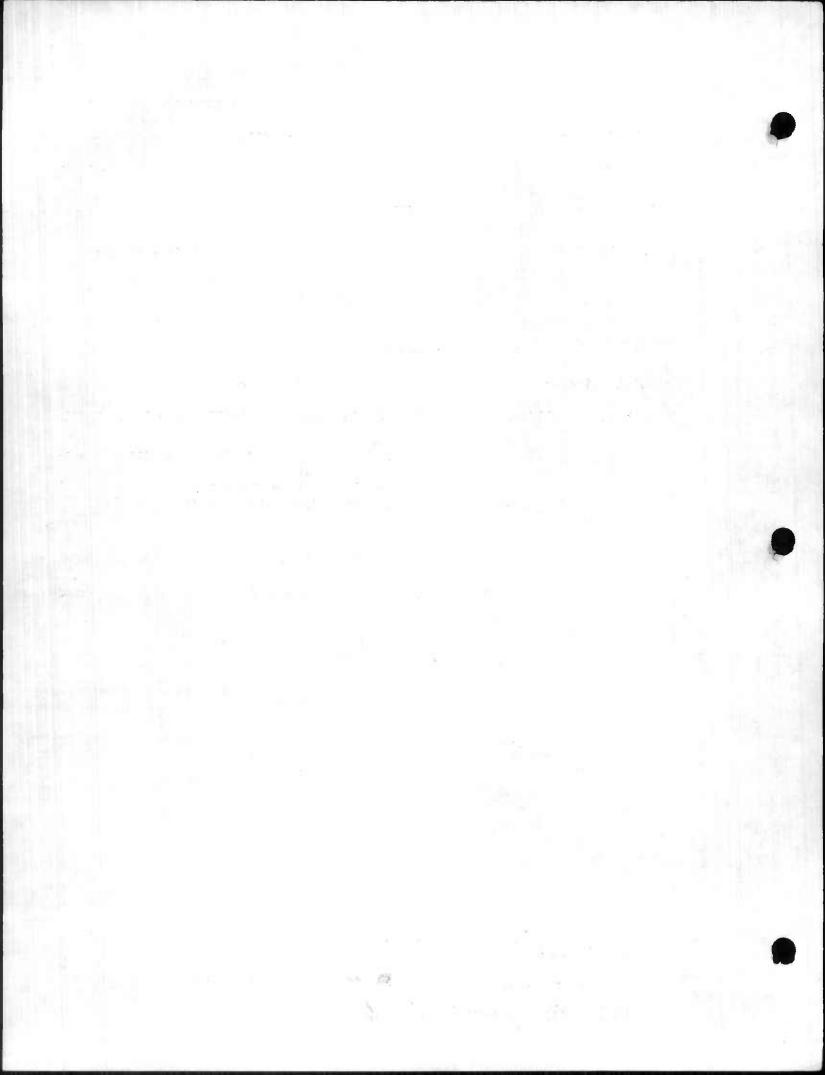


State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician FDITH** Μ. FOXWELL JANUARY 15 1999 1:15 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1800 Lewis Avenue Rockville Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 25 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Months 218-01-1950 88 Aug. 1910 Director Maryland Usual Rasidence of Decedant 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 25a-f show must be notified at Maryland Montgomery Rockville 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 125 Charles Street 20850 United States flerms 23s Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Merital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: White Specify: À 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homema ker Own Home emil. Pages 1 and 2 should be filled bepartment of Health and Mental Hygi-mportant: If Nem 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Randolph Windsor Ida Burdette 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Kenneth W. Foxwell/son 1800 Lewis Avenue, Rockville, Maryland 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete Parklawn Cemetery 1/19/99 Rockville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Fecility 23e. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest.

Maryland 20882 Muriel H. Barber Approximate totarval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition rasulting in deeth) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Box 68760, Physician/Medical Heait facture 980 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco usa contributa to the cause of death? Records, P.O. 1 ☐ Yea 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy performed? peeu completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

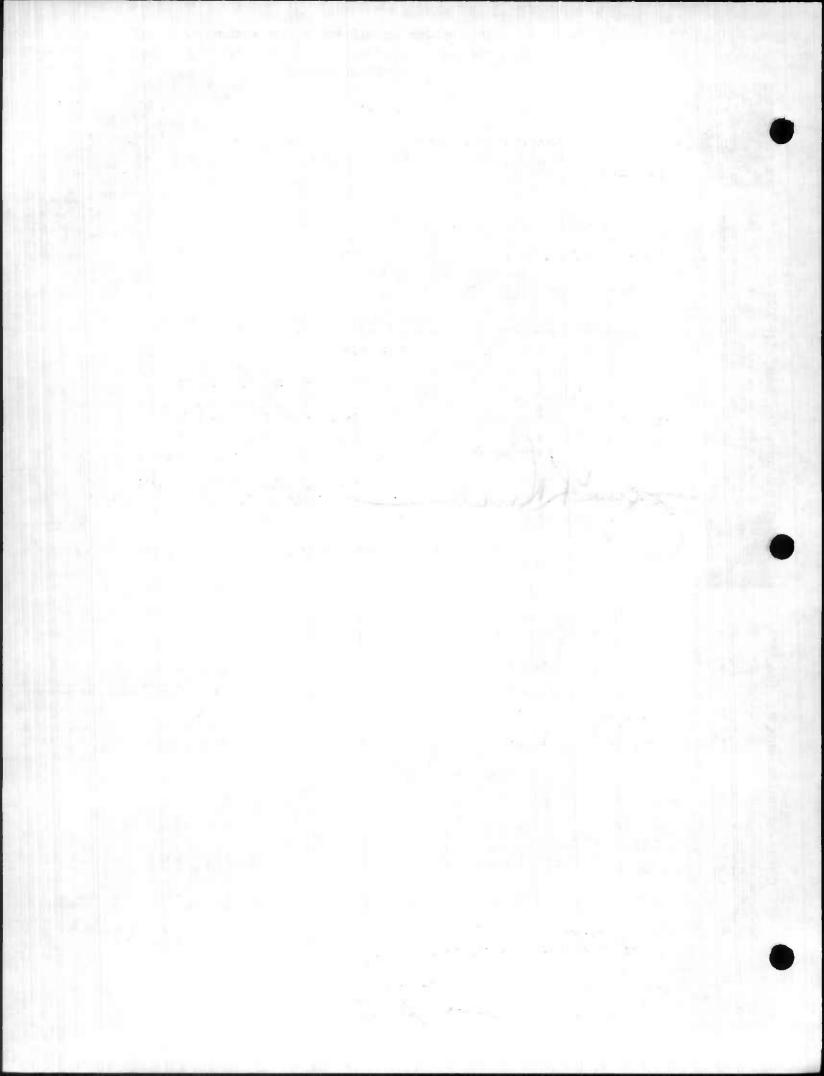
To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Aveturel 2 Accident 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be datermined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homloida 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) end interime as a state.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) end menner steted. edicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Dr. K. S. Kim 30. Neme and address of person the completed ceuse of death (Item 23a) (Type, Print) Edmonston DR. VILLE MD w. 31. Dete liled (Month, Day, Year) 32. Registrer's Signeture State JAN 19 1999 Registrar



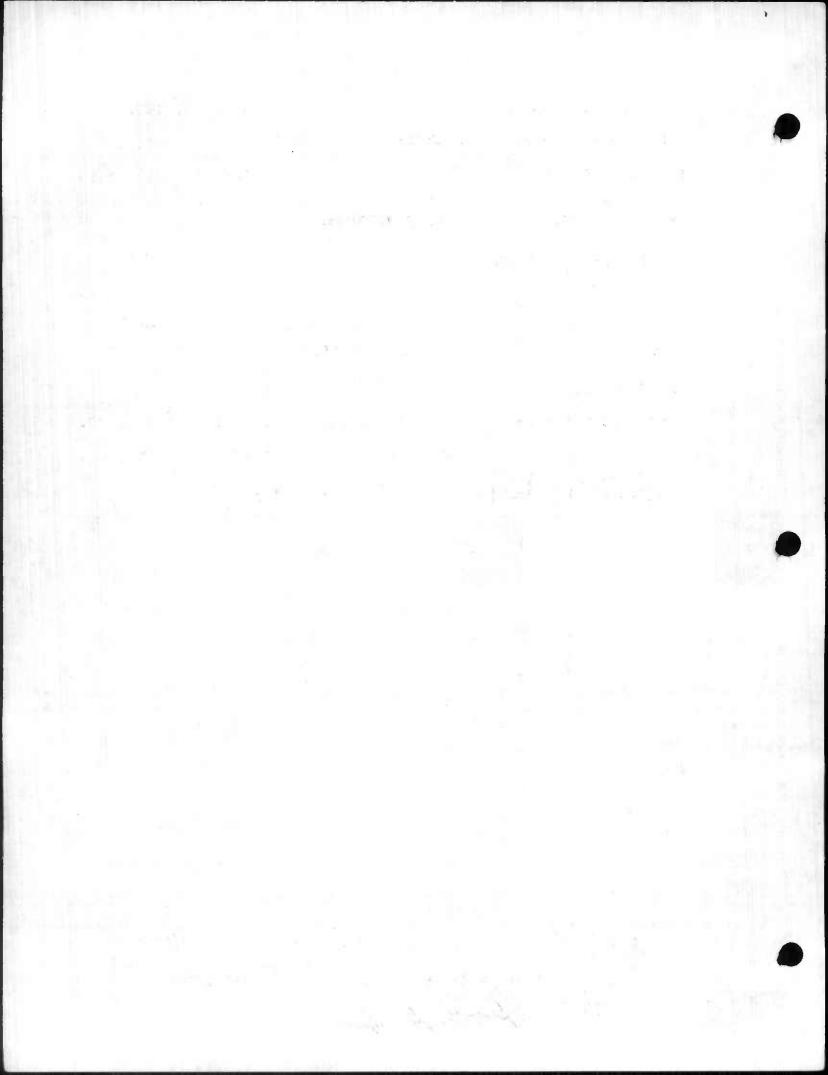
Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nar	ne (First, Middle	, Last)						2. Date of De		Verr	3. Time of Death
nysician	MICHAEL		G.		FR	ISHER			Month 1	Day 1.3 1	999	10:45 PM
Medical xaminer	4a Fecility Name	(If not institution	, give street and nu	m <i>ber</i>)			4	b. City, Town, or L	ocation of Deet	h 4c. Count	y of Death	
	HEBREW H	OME OF	GREATER W	ASHING	CON			ROCKVII	LLE	MONT	GOMER'	
neral ector	5. Social Security 104-14-4	701	8. Sex 1 M 2 □ F	7. Age (In yrs. 85		If Under 1 Months I		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11-28-	th Year) -13	9. Birthple Country AUST	ace (Stete or Foreign ov) RTA
3 .	Usual Residence	10b. Counfy		10c. Ci	ty, Town or Lo	cation					10	d. Inside City Limits
Director	FL.	DADE		N.	MTAMT	BEACH						
ust be no	10e. Street and N					10f. Zip C				10g. Citizen of	What Counti	ry?
ira ir		E. GARD	ENS DRIVE			331		1.011.010		USA	an America	- 1- 6
Examiner must by Funeral		ried 2 Marri	Armed Fo	2 ☒ No ve		Was Deceder f Yes, specify 1 ☐ Yes 2 ☑	_	spanic Origin? (Sp n, Mexicen, Puerto Specify:	oechy Yes or No Rican, etc.)	Special	ce - America ick, White, e fy: WH	
Completed	/Co.	15. Decedent	's Educetion it grede completed)		16a. Deced	dent's Usual (Occupa	ation during most of work	kina	16b. Kind of E	usiness/Indu	ustry
omple	Elementary/Sec		Collega (life. L	DO NOT use	retired)	ang .			
So				3+	EXP	PORTER				SCALES		
Be	17. Father's Name							18. Mother's Nam			me)	
2	GEDALIA											
	GAIL WOL		DAUGHTE	ER				and Number or Ru RDEN WAY		CHURCH,		
	20a. Method of Di 1 Durial 2 4 Donation		3 El Flomoval from	State	Place of Dispo cem <i>etery, cre</i> n MORIA	natory or other	of er plac		Date 1-15-99	FAIR V		
9000	21. Signature of F	mes A	Rele	la				GOLDBERG LLLE PIKI				
an	25s. Part1. Enter shock, or he	the disease, or an failura. List	complications that conly one cause on	caused the deep each line.	th. Do not ent	er the mode	of dyin	g, such as cerdiac	or raspiratory a	rrast,		Approximata Interval Between Onset and Death
ical ner	disease or condition	on	a	RESPIRA'	TORY I	NSUFF	ICI	ENCY				MONTHS
ner l				COPD Due to (or as a conseq	quance of):						
Examiner	Sequentially list of any, leading to cause. Enter Und Cause (Disease that initiated even	onditions, mmediate	6	Due to (or as a conseq	juence of):						
Medical Examir	Cause (Disease of that initiated even resulting in death)	r Injury ts Last	C	Due to (c	or as e conseq	uance of):					1	
Physician/N			0						001 014			
Physi		NOMA OF	ns contributing to d	eath but not res	sulting in the ui	nderlying cau	ise giv	en in Part I.		Yes 2□ No		the cause of death?
Completed by Physician/M	CARCI	INOMA OI	PROSTAT	Ξ.					24a. Was	s an autopsy omned?	ava	re autopsy findings ilable prior to appletion of ceuse
ompie									10	Yes 2√2 No	of d	eath? Yas 2□ No
rector, page 2	25. Was cese rafe	rred to medical						26. Place of Dea				
al director.	axaminer?	No.	Hospital:	Inpatient 2	ER/Outpatien	nt 3 DOA	Oth	or		idence 8 🗆 Ot	her (Specify)
ation: T	27. Manner of Dea 1 Natural 2 Accident		28a. Data (Mon		28b. Time of Injury		Nori	23		how Injury occu		
Certification:	3 ☐ Suicide 4 ☐ Homicida	6 Could r determ	ined 288 Place	of Injury - At hing, etc. (Special	ome, farm, str	eet, factory,	office			(Street and Nurr wn, State)	ber or Rural	Route Number,
compietely filled in by the funeral Medical Certification: 1	29a. Certifier (Check only one)		g Physician: To the Examiner: On the b									
e E	29b. Signature en	diffe of cogition		1		29c. I	Licens	e number		29d. Dete sign	ed (Month, L	Day, Year)
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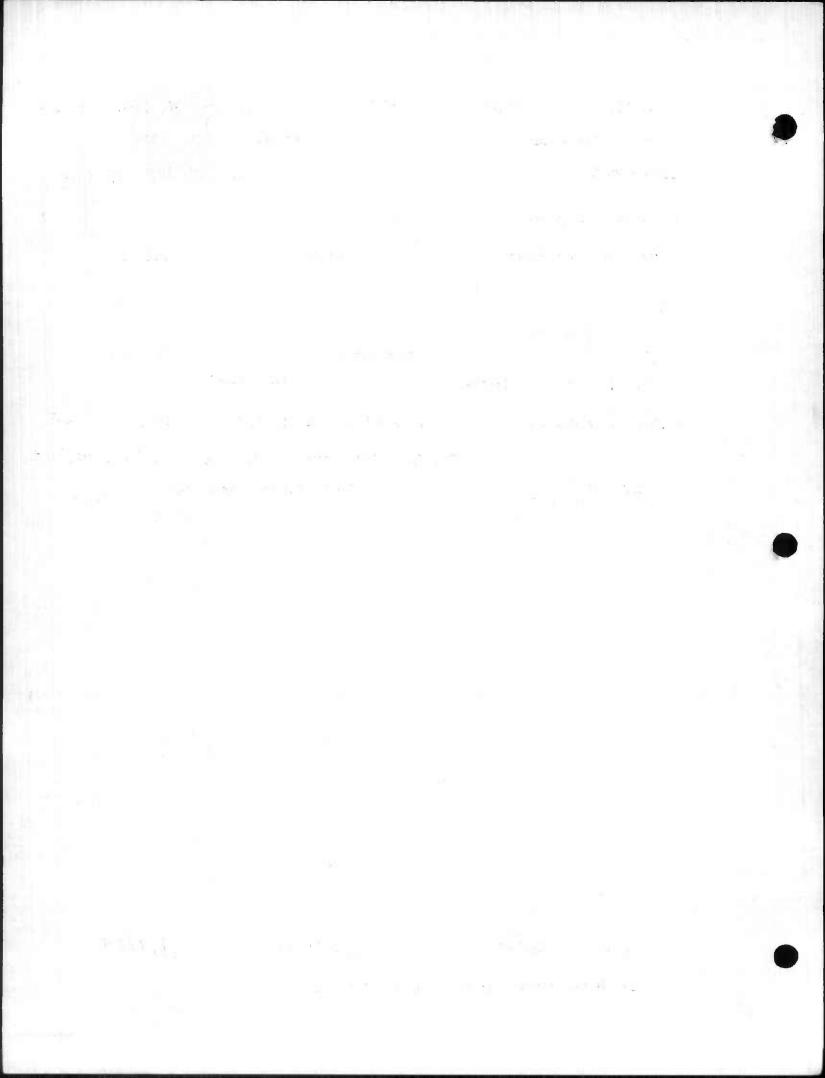
State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Dey **Physician** Month OTIS J. FULLER 13, 8:23PM JAN. 1999 /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner PRINCE GEROGE'S HOSPITAL CENTER CHEVERLY P.G. If Undar 1 Yaar if Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours 1⊠M 2□ F Yrs. 579 01 8960 86 Director JUNE 13 1912 S.C. Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location must be notified at 10d. Insida City Limits 1 Yas 2 No Director MD. P.G. SEAT PLEASANT 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Нета 23а 20743 Funeral USA 5708 COOLIDGE STREET 12. Was Dacedant Evar in U.S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 "nature", or 1 ☐ Yas 2 ☐ XNo Specify: BLACK by 3 ☐ Widowad 4 ☐ Divorcad Completed 16e. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacadant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) Hygiene. other than Elamentery/Secondary (0-12) College (1-4or 5+) RAIL ROAD permit. Pages 1 and 2 should be littled in Department of Health and Mental Hygen important. If Item 27 is marked other the any or other traumatic conce. MAIL HANDLER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) JOHN FULLER MARY HIGGINS 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) FULLER/WIFE 5708 COOLIDGE ST., SEAT PLEASANT, MD.20743 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata CEDAR HILL CEM. 1/22/99 SUITLAND, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility WATSON F. H.INC. 23a. Part1. Enter the disease, or complications that cabsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onsat and Death **Physician** /Medical Immediata Causa (Final Sepsis Staphylococcal diseasa or condition resulting in deeth) Examiner to (or as a consequence of): Physician/Medical Examiner The law requires that the deeth certificate be executed pug Sequantially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disaese or Injury that initiated avants resulting in death) Last Dua to (or es a consequance of) physiclan e Box 68760. Dua to (or as a consequence of). P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? direase / perphoral vucular 1 Yes 2 No 3 Probably 4 Unknown diserre signed t Records, à Be Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? page 2 should thee Amputation , arterial insufficiency # 4 per tenim / prostatectury certificate 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa rafarrad to medical axaminar? 26. Piece of Daath (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 // s efter des. real Director: After to. 28a. Date of Injury (Month, Day Year) 27. Manner of Daath 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding Invastigetion 1 Yes 2 No 2 Accidant 6 Could not be detarmined 3 Suicida 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicide 24 hours e Funeral D 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner es steted.
2 Medical Examiner: On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. Medicai completely (Check only To the I within 2 To the F 29d. Data signed (Month, Day, Year) 29b. Signature and title of certified 29c. Licansa number 30. Nama and andress of parson who complated causa of death (Itam 23a) (Type, Print) PG Hopp 300/ Hosp Drive Cheverly MAS 20781 32. Registrar's Signatura State Registrar



State of Maryland / Department of Health and Mental Hygiene Q Q 0 251, Q

						Certifica	ate of D	eath	Re	g. No.	06	049
	Physici	an	1. Decedant's Nema (First, Middle, La	*		ETNE			2. Dete of Deet	n _		. Tima of Death
	/Medi		KATHLEEN	ELIZABETH		FINE	[0) 7	January		999	6:20 AM
	Examir	ner	4a. Facility Name (If not Institution, given Genesis Elder	Care				LaPlata			arles	
D	uneral irector			Sex 7. Age	74	Yrs. If Und Month		Hours Min.	8. Date of Birth Month, Day Jan. 30	, 1924	9. Birthplece Country) Virgi	(State or Foreign
yland	Mon		10e. Stete 10b. County		10c. City, Tow						10d.	Inside City Limits
e Mar	P P	ctor	Maryland Char	les	Wa	ldorf						1 ☐ Yes 2 🕅 No
oth with th	23a or 2 ust be n	Funeral Director	100. Street end Number 1160-A Heritage	Place		10f. 2	Zip Code 2060	2	10	og. Citizan of V U.S.		
Naryland 21215-0020 2 should be filed within 72 hours effer deeth with the Maryland	n recent survivalent ryperior other 23a or 28a-f show from 17a must be notified at other traumatic event, the Medical Exempler must be notified at	by	11. Meritel Status 1 Nevar Marriad 2 Merried 3 WWidowed 4 Divorced	12. Was Dacedant E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yaar or Dates;				penic Origin? (S , Mexican, Puer Specify:	specify Yas or No- to Rican, atc.)		e - American I ik, Whita, atc.	ndian,
2-0	dical	Completed	15. Decedent's E (Specify only highest gre	ducation ade completed)	16a.	Decedent's U	suai Occupat work dona du	ion ring most of wo	rking	6b. Kind of Bu	siness/Indust	ry
vithin	than the	Jupi	Eiementery/Secondery (0-12)	College (1-4or 5-	-)	Home Ma				0wn	Home	
and and d	ed other	Be	17. Fathar's Nama (First, Middle, Last Unavailable	Baxter		TOME MA		8. Mother's Na. Una\	ma (First, Middle, Nota i lable			
S 2 5	27 is mark r traumati	To	19e. Informent's Neme/Relationship (ural Route Number, , Waldorf			²⁰ 20602
(I)=	Important: If item 27 any Injury or other to once.		20a. Mathod of Disposition 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specie	Removel from State	cemata	f Disposition (A ry, crematory o untt Cr	r other pieca,		Dete 2 1-23-99	Wald		Stata aryland
Department of H	Importa any Inju		21. Signature of Funeral Seption Lice	· R	164	Tho	and Address Huntt	Fungra	1 Home, 1	inc.	d 206	04
	/sician ledical		JOHN P. KNISL 23a. Part1. Enter the diseese, or comshock, or heert feilura. List only Immediate Cause (Finel disease or condition	plications that caused one cause on each lin	the deeth. Do	not anter the m	node of dying,	such es cardie	c or respiretory erre	st,	Ap Intr On	proximate arval Between set end Death
of buy	nding physician and use as the buriel-transit	n/Medical Examiner	Sequentially list conditions, if any, leeding to immadiete cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in deeth) Last	c		consequenca o	of):	lete n	elliles			
de at	e attendii ed for use	Physician/	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	n the underlying	g cause giver	ı İn Pert I.	23b. Did tol	bacco use col	ntribute to the	cause of death1
o, T.O	ned by the a detached	by Phys		•					1 🗆 Ya	8 2□ No	3 Probabi	y 4 🖺 Unknow
he lew requires that	has been sign je 2 should be	Completed b							24e. Wes ar perform		availat	autopsy findings ble prior to ation of cause th?
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or Attending after deeth.	Director: After d in by the funer	ertification:	1 Neturel 5 Pending 2 Accident Invastigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Pieca of Inju	ry - At home, fe	M m, street, fect	1 🗆 Y	es 2 No	28f. Location (Str		er or Rural Ro	oute Number,
7 6 4	To the Funeral Direct completely filled in by	O	4 Hornicide	ysician: To the best of		death occurre	ad at the time	date and piece	City or Town		nnar as state	1
Me Hos	Ne Funeral bletely filled	edicai	(Check only one)	niner: On the basis of end menner stet	examinetion en	d/or Investigeti	on, in my opl	nion, deeth occi	urred et the time, de	te and piaca,	and due to the	cause(s)
To the within 2	To th	M	29b. Signatura and title of certifiar Mul C 1	evito			29c. Licansa 2002		29	d. Dete signed	Month, Dey	, Year)
7			30. Name end eddress of person who	completed cause of de	eth (Item 23e)		-					
			Dr. Michael			Box 24	19, Wa	ldorf,	MD 20604			
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registre		h	1					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey **Physician** 13, 1995 4c. County of Death Joseph Leonard 11:45 P.M. Frey, Jr Jan. /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) **Examiner** Golden Age Guest Home Sykesville Carlo If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Carroll If Under 1 Year 6. Sex **XX**M 2□ F Birthplece (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Deys 81 Yrs. July 19, 1917 Maryland Director 213 09 6256 Usual Residence of Decedent with the Marylend permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Heelth and Mental Hygiana.
Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any Injury or other traumatic event, the Modical Examiner must be notified at pace. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Carroll Sykesville 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 7611 Maple Ave. 21784 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Raca - American Indien, Black, Whita, etc. 11. Merital Status 1 Yas 2 No If Yes, Giva Year or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Vending College (1-4or 5+) Elamantary/Secondary (0-12) A.R.A.Services Dispatcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Joseph Leonard Frey, Sr. Catherine Smith 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 7611 Maple Ave. Sykesville, Md. 21784 Ruth N. Frey (wife) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 № Buriei 2 Cremation 3 Removal from State Springfield Cemetery 1/17/99 Sykesville, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenses Sykesville, Md. 21784 23e. Pai 1. Enter the disease, or complication what causad the shock, or heart dilure. List only one cause on each lina. Haight Funeral Home & Chapel P.O.Box 195 hat causad tha death. Do not antar the mode of dying, such as cardiac or respiratory arrast, Approximata Intarval Batween Onset and Deeth **Physician** Immediate Cause (Final diseasa or condition resulting in daeth) /Medical Examiner Examiner may flewater physician and the bunal-transit the death certificate be executed Sequantielly list conditions, if eny, leading to Immediate causa. Entar Undarfying Causa (Disease or Injury that initieled events resulting in deeth) Lest Que to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): USB 8S for signed by the e 23b. Did tobacco use contributs to the cause of death? Pert ii. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Wara eutopsy findings aveilable prior to completion of ceuse of death? should t 24e. Wes en eutopsy performed? Completed is certificata has director, page 2: 1 Yes 2 PNo 1 Yes 2 No Physicien: 25. Was casa rafarred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28b. Time of 28d. Describe how Injury occurred 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: ne Hospital or Attending Pi n 24 hours after death. Ne Funeral Director: After the pletely filled in by the funera After 1 PNeturel 5 Panding 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Cartifier 1 🖰 Certifying Physician: To the best of my knowledge, daath occurrad at tha tima, date end plece, and due to the ceuse(s) and menner as stated. edical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the besis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, dete end place, and dua to the causa(s) end menner steted. (Check only one)

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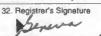
ATRICK 31. Date filed (Month, Day, Year)

29b. Signeture and title of certifier

/welgus 30. Neme and eddress of person who completed ceusa ol deeth (Item 23a) (Type, Print)

NO

/URNES



1425 Wherty

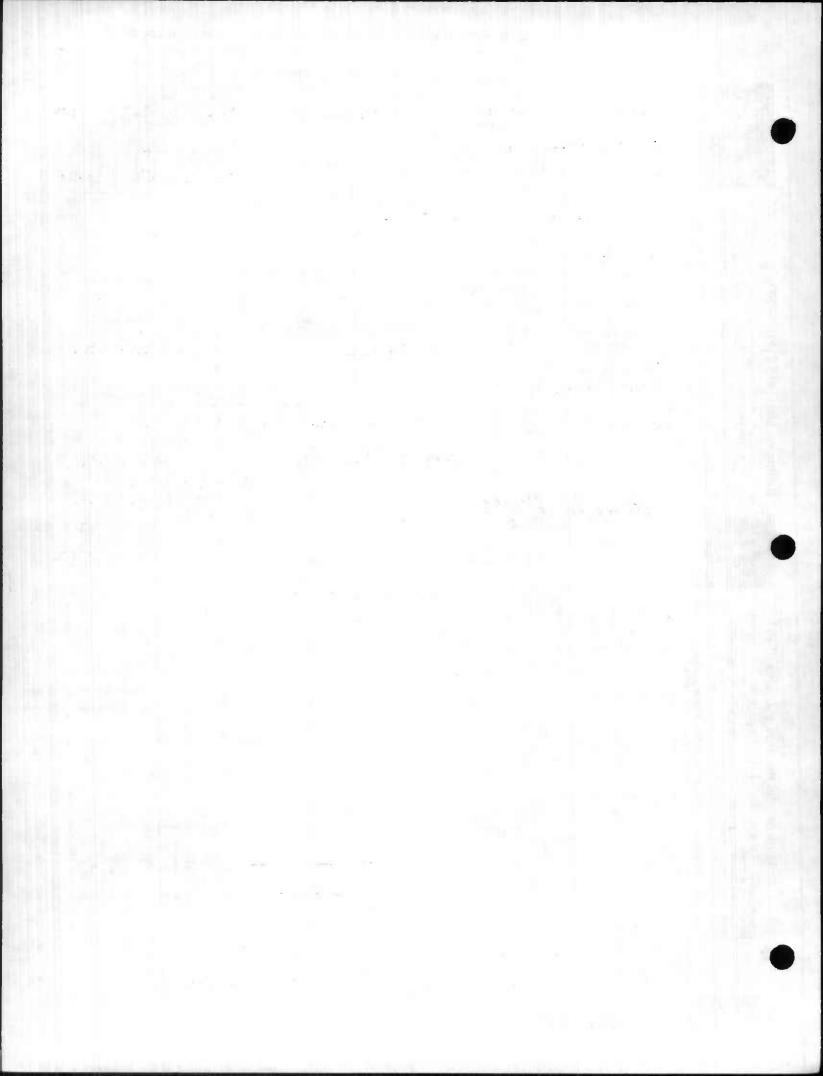
29c. License number

20806

Eldersby MD

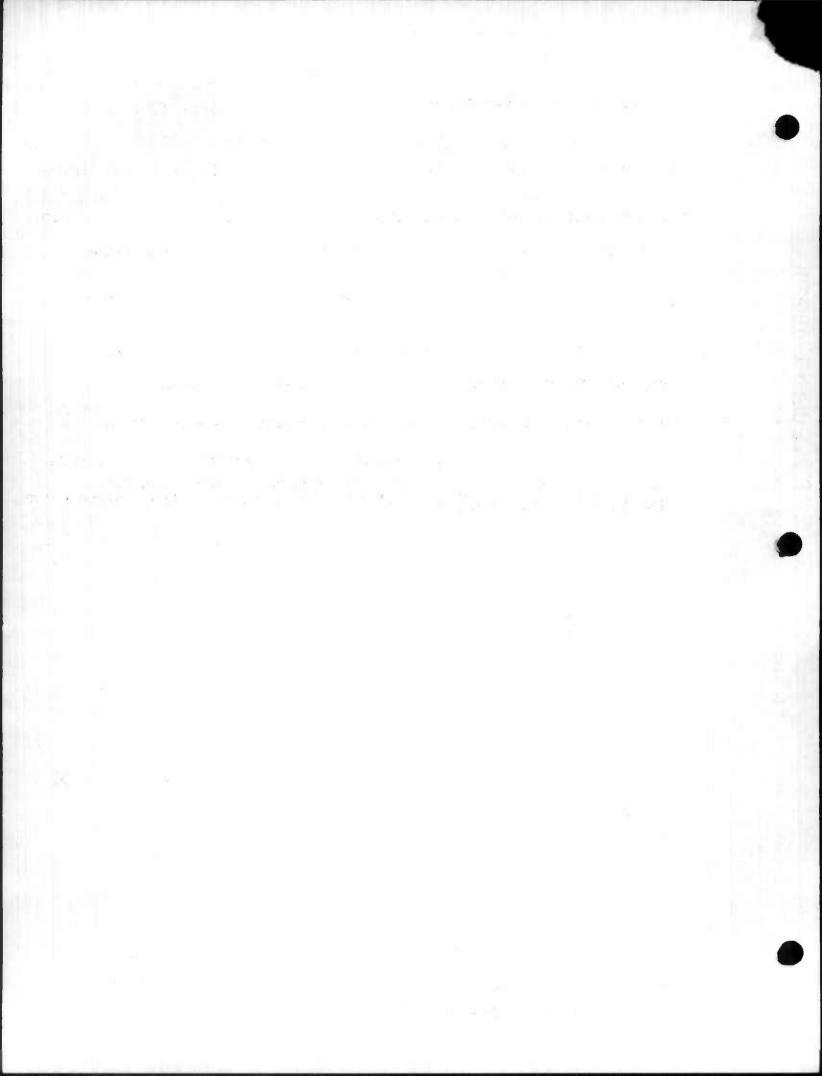
29d. Dete signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 99 0255

						Certifica	ate of	Death		Reg. No.	3 02	166.
	Physic	ian	1. Decedant's Nama (First, Middla, Las Marguerite		2++				2. Data of E Month	Death Day	Veer	Tima of Death
	/Medi	cal			100			th Oh Tour	JANUA	1		9:06 PM
7	Exami	ner	4a. Facility Nama (If not institution, give	street and number)	Mar	DITAL		46. City, Town,	or Location of Dea			MOLO
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	Director			□M ¾QXF	79 h	/rs. Month	ns Days	Hours	Min. 8. Data of E	1919	West V	(State or Foreign Virginia
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	Maryl f sho	to	Maryland Prince G			ville						1 ☐ Yas TONO
	s with the Maryland 3a or 28a-f show at be notified at	Funeral Director	10e. Street and Number 3608 Jaywood Av	enue		10f.	Zlp Coda 20747	7			What Country?	
Maryland 21215-0020	rurs after death with the Marylar af, or thems 23a or 28a-f show Examiner must be notified at	by	11. Marital Status 1 Navar Married 2 Marriad XX Widowad 4 Divorced	12. Was Dacedant Evar in Armed Forces? 1 ☐ Yas ŽŽŽNo If Yas, Giva Yaar or Datas:	U,S.			dispante Origin an, Maxicen, P Spacify:	? (Specify Yas or Nuarto Rican, atc.)	lo- 14. Ra Bla Specii	ce - Amarican lack, Whita, atc.	
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Baltimore,	permit. Pages 1 and 2 ahould Department of Health and Mer Important: If them 27 is marks any injury or other traumatic otice.		20a. Mathod of Disposition **Durial 2 Cramation 3 4 Donation 5 Other (Specify	Ramoval from Stata	cematan	Disposition (for cramatory of Cemet	r othar pla	*	Data 1/14/1999		- City or Town,	
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Box 68760,	that the death certificate be executed of by the attending physician and deteched for use as the burial-transit	an/Medical Examiner	Sequantiatly list conditions, if any, leading to Immediate ceuse. Entar Undarthying Cause (Disease or Injury that initiated avants rasulting in death) Last	C		onsequance o						
	deat he att	Physician/	Part II. Other significant conditions co	entributing to death but not r	asulting In	tha undariyin	g ceusa giv	van in Part I.	23b. DI	d tobacco use co	ontribute to the	cause of death?
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Division	i Digit	Certification:	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida datarmined	28a. Place of Injury - Al building, atc. (Spe	homa, far	m, street, fact	ory, office			(Streat and Num. own, Stata)	ber or Rural Ro	outa Number,
	To the Hospital within 24 hours of To the Funeral completely filled	edical	29a. Cartiflar (Check only one) 1 Certifying Phy 2 Medical Exam	raician: To the best of my k iner: On the basis of axami and mannar stated.	nowledga, nation and	daath occurre Vor invastigati	ed at tha tir on, in my c	ma, data and p pplnion, daath o	lace, and dua to the occurred at the time	a ceusa(s) and m ı, data and place,	annar as stated and dua to tha	d. i ceusa(s)
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	01		Karen 50065 31. Data filed (Month, Day, Year)	32. Ragistrar's Sig	aux	S HV	2 1	HIEXQ	nona	VA	156K	1
	Sta	te		QQ 32. Hadistrar's Sig	- latura	4	100. 4	11				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death GASTON Month GERALDING. 9-55 AM January 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not Institution, give street end number) HOWARD Columbia Howard County General Hospital If Under 24 Hrs. 8. Data of Birth (Month, Dex Year) 922 7. Age (In yrs. last birthdey) If Undar 1 Yaer 9. Birthplace (State or Foreign 5. Social Sacurity Number 6. Sex Days 1□M 2XF Months Wash. DC 76 Yrs. 579-42-6653 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Columbia 1 Yes 2 □ No Howard MD 10g. Citizen of Whet Country? U.S.A. 10e. Street and Number 10f. Zip Code 21044 5495 Cedar Lane 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yaar or Detas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Merital Status 1 □ Navar Merried 2 □ Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) College (1-4or 5+) Elementery/Secondary (0-12) U.S. Government 2 yrs Cook 18. Mothar's Name (First, Middle, Maiden Surnama) 17. Fathar's Neme (First, Middle, Last) Unknown Louise Mannagin 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Janice Powell (Daughter) 5645 Phelps Luck Dr., Columbia, MD 21045 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 Deurial 2 Cremetion 3 Removal from Stata 1/20/99 Harmony Memorial Pk Landover, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Fecility SNOWDEN FUNERAL HOME, P.A. Signature of Funeral Service Licensee ROCKVILLE, MD 20850 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on aech line. Approximate Interval Between Onset and Death Immediate Cause (Final one week SEPSIS diseese or condition resulting in death) Due to (or es e consequence of): Tract one beass Urinary Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or es e consequence of): 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Artery D'Sease 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 20 No 1 Ves 20 No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner the death certificate be axec

Physician

/Medical

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Director

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Completed

Funeral

Director

7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be a

Pages 1 and 2 should be file ment of Health and Mental Hyant: If item 27 is marked oth jury or other traumatic every

permit. Page Department of Important: If eny injury or once.

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filed within 72 hours after death

Baltimore, Maryland 21215-0020

ician and burial-trans physician s the bunal as 950 signed by the a page 2 s ils certificate h this

Division of Vital Records, P.O. Box 68760,

or Attending Physicien:

Examiner Physician/Medical à Completed Be 0

funeral After after death. Director: Aft

27. Mannet of Deeth

1 Neturel

2 Accident

3 Suicide

29e. Certifier

4 Homicide

25. Wes cese referred to medical exeminer? 1 Yes 2 No

5 Pending investigation

6 Could not be detarmined

28a. Dete of Injury (Month, Dey Year) NIA

28b. Time of fnjury 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

NA

28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury occurred NA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signatura and titla a certifier, N-5.10

29c. License number .30469

29d. Date signed (Month, Day, Year) Join may 14/4- 1999.

30. Name and address of person who completed cause of death (from 23e) (Type, Print).

N. B. VELLANKI, 9055, CHEVROLET DRIVE: #100 - ElliCATT City: M.D. 21042 31. Deta filed (Month, Day, Year)

1 Certifying Phyalcfan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

State Registrar

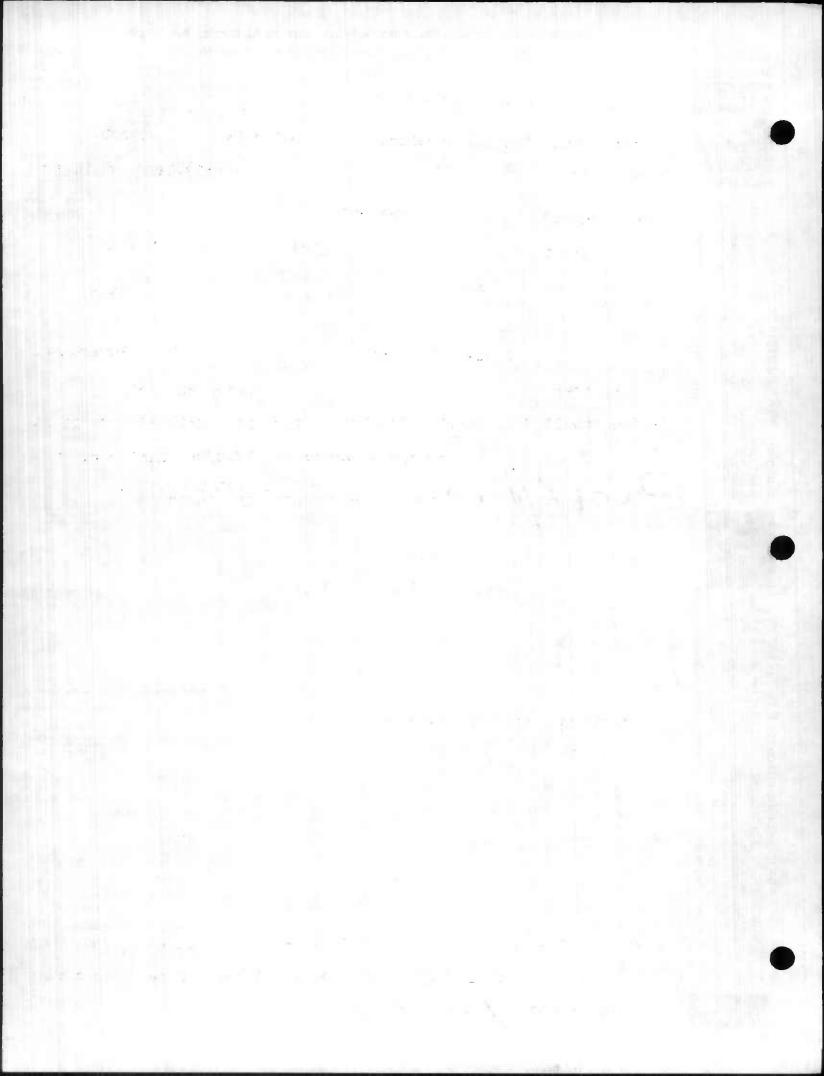
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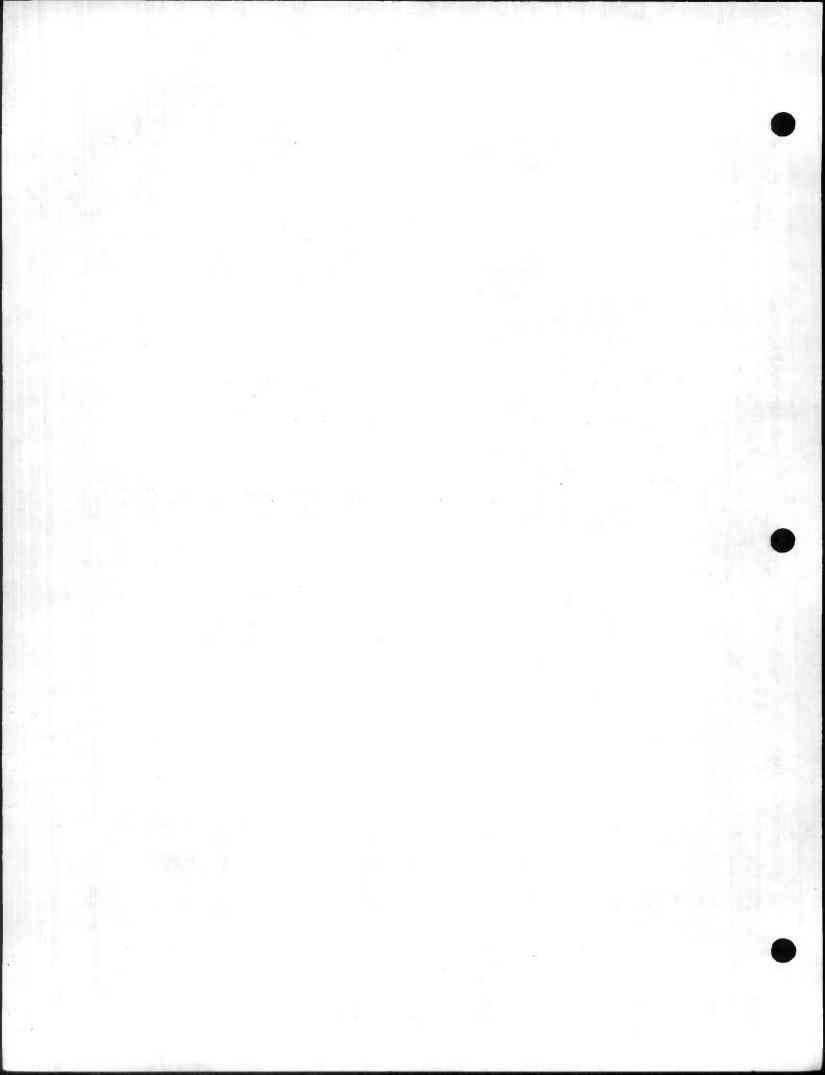
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JAN 1 9 1999

32. Registrer's Signeture



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Diverwed Action Consider Specify		_				Specify Yes or No	- 14. Rece		ndien.
College First College	1 Never Merried 2 Merried	Armed Forces? 1 Yes 24 No If Yes, Give				to Rican, etc.)		· Setting to	HITE
Elementary/Secondary (0-12) College (1-4cr 5+) ENGINEER MECHANICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surreme) 19. Informant's Name/Feletionship (Type, Print) 19. Informant's Name/Feletionship (Type, Print) 19. Informant's Name/Feletionship (Type, Print) 19. Mailing Address (Street and Number or Pural Boute Number of Coll DA O'STRAKH 18. Mother's Name (First, Middle, Maiden Surreme) 19. Mailing Address (Street and Number or Pural Boute Number of Coll DA O'STRAKH 18. Mother's Name (First, Middle, Maiden Surreme) 19. Mailing Address (Street and Number or Pural Boute Number of Coll DA O'STRAKH 18. Mother's Name (First, Middle, Maiden Surremen) 19. Mailing Address (Street and Number or Pural Boute Number of Coll DA O'STRAKH 18. Mother's Name (First, Middle, Maiden Surremen) 19. Mailing Address (Street and Number or Pural Boute Number or Pural B			16a. Dec	edent's Usuel Occupe kind of work done	pation during most of wo	rkina	16b. Kind of Bu	siness/Indust	гу
MAYER CORBAN 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 13803 GREY COLT DR., GATTHERSBURG, MD 20878 20a. Meptind of Deposition 1. Burial 2 corrections of Cherk (Special Schools) 1. Burial Corrections of Cherk (Spec		College (1-4or 5+)	life	DO NOT use retire	d)		МЕСН	IANICAL	
19b. Informant's Name/Reletionship (Type, Print) TANYA KAPLAN / DAUGHTER 20b. Meging Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18803 GREY COLT Dr., GAITHERSBURG, MD 20878 20b. Meging Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Melling Address of Scaling 19b. Melling Address o		1)						(0)	
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Carried and Department of Surperson Statements and Surperson State	20a. Method of Disposition		20b. Place of Dis	position (Name of	Ţ				
22. Name and Address of Facility DANTAL STMONS DANTAL Collaboration of Facility DANTAL Enter this dishase, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, interest of classes, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, interest of classes or condition resulting in death) Due to (or as a consequence of): Due to for as a consequence of): a. CANDO DUE to br as e consequence of): Due to for as a consequence of): Company How the conditions or him or the caused the conditions of the caused place or him or the caused place or the						/22/99	OLNE	Y, MD	
28a. Part Letter ple disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximated a cause (Finel disease or condition resulting in death) Bue to (or as a consequence of): Convert Hundring that initiated events resulting in death) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause in Part I. 24a. Wes en eutopsy performed? 24b. Wers and conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Wes en eutopsy performed? 24b. Wers and conditions contributing to the cause (all part and conditions of death?) 1 Yes 2 No 2 No 1 Yes 2 No 2	21. Signature of Funeral Strvipe Licer								
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27. Manner of Death 1 Inpatient 22 EMOutpatient 3 DOA 4 Nursing Home 5 Headence 6 Other (Specify) 27. Manner of Death 1 Inpatient 22 EMO 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Nove 28c. Injury at	examiner?	Hospital:		Ot	her				
3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, fectory, office 28f. Location (Street and Number or Rural Route in City or Town, State) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year Town)	27. Manner of Death 1. SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Y		of 28c. Inju	ry at rk?	T			
29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year Day) 29d. Detection on 19d and		28e. Place of Injury	y - At home, farm, t (Specify)	street, fectory, office				er or Rural Ro	oute Number,
D39190 JANUA 20, 19	3 Suicide 6 Could not be			the second at the st	me, date end place	e, end due to the	cause(s) and ma	nner as stated and due to the	d. cause(s)
	3 Suicide 4 Homicide 29a. Certifier (Check only 1 Certifying Ph	miner: On the basis of ex	xaminetion and/or	investigation, in my	opinion, deeth occu	irred et the time,			
	3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	miner: On the basis of ex	xaminetion and/or	investigation, in my	opinion, deeth occu			d (Month, Dey	, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Garrett Reilly, M.D. 3418 Olandwood Gr. #111 Olney MO 20832	3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	miner: On the basis of ex	xaminetion and/or	29c. Licens	opinion, deeth occu se number		29d. Dete signed		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Gordon 1:31 am Anita 99 January 16 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 24 Hrs. If Under 1 Year 6. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 M 2 TF Yrs. Director 102-22-2770 JULY 9, 1923 NEW YORK Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits herrs 23a or 28a-f show ner must be notified at 1X Yes 2 No Directo MD. MONTGOMERY BETHESDA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 7500 EXETER RD. 20814 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER AT HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 2 KARL ROBBINS MARY KIVELSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if them 27 is any injury or other traus THOMAS W. D. WRIGHT/HUSBAND SAME AS ITEM #10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 1/19/99 CHAMBERS CREMATORY RIVERDALE. MD. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility 20910 M00091 CHAMBERS FUNERAL HOMES, P. A., SILVER SPRING, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Renal Failure months Examiner Due to (or as a consequence of): Examiner Multisystem Organ Falure The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Intected Pancreatic Pseudocys Physician/Medicai the Due to (or as a consequence of): for use as onth Acute Dancreatitis Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, g 9 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 Yes 1 Yes 2 No 2 □ No Division of Vital after death.

Director: After this certifica director. 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA edical Certification: To funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral C completely filled pelli To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Surgical House Officer RES-DOD January 1,1999 10 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) David J. Caparelli 903 W. Univerty Parkury #201 Baltimore, MD 21210 31. Date filed (Month, Day, Year)

JAN 19 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Month Yası 115a1m Green 1999 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Park mont Hoven Takoma NOSP しゃりりかりか 9 Oaner4 9. Birthplaca (State or Foreign Country) If Undar 24 Hrs. If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours 1♥M 2□F 577-92-5092 APR. 2 S. CAROLINA Usual Rasidence of Decedent 10d. Insida City Limits 10a. Stata 10b. County 10c. City. Town or Location t ☑ Yas 2 ☐ No MD. MONTGOMERY TAKOMA PARK 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. AVE. #207 20912 7051 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE RET. - MAINTENANCE MAN 18. Mothar's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middle, Last) UNKNOWN UNKNOWN 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 MANCHESTER RD. #5, SILVER SPRING, MD.20901 GREEN/ DAUGHTER GAYNELLE R. 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Data 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 1/20/99 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funaral Sarvice Liganium 22. Nama and Addrass of Facility MOOO91 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. ta death. Do not entar the mode of dying, such as cardiac or raspiratory arrest 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Batween Onset and Deeth Immediata Cause (Finel diseasa or condition rasulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings svailabla prior to complation of causa of death? 24a. Was an autopsy performed? 1 Yes 1 Yas 2 No 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 2 Accident

Examiner physician and s the burial-transit certificate be executed Box 68760. Physiclan/Medical 60 980 P.O. Records, þ Completed has certificate Division of Vital Be Certification: To this funeral

cepital or Attending Physician: hours after death. Director: A To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by

Physician

/Medical

Examiner

Director

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"natural", or Items 23s

filed within 72 hours after Hygiene. ther then "naturel", or its

permit. Pages 1 and 2 ahould be filled wit Department of Health and Mental Hygiens Important: If them 27 is marrised other that any Injury or other traumets.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

29a. Certifier

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

28a. Place of Injury - At homa, ferm, street, lactory, office building, atc. (Specify)

29b. 5 g ture and title of certifies 4m DMG

5 Pending invastigation

6 Could not be detarmined

29c. License number D004

1 Yas 2 No

29d. Data signad (Month, Day, Year) 16

20902

Dr

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print)

BRECHER, MO OME 31. Date filed (Month, Day, Year) JAN 2 1 32. Regi

strar's Signatura

State Registrar

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A E A E A E .

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 3. Time of Deeth 1 Decedent's Name (First Middle Last) **Physician** Elizabeth Parks Gibson 2:00 AY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Frederick Memorial Hospital Frederick Frederick ti Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 KF 88 Yrs. Oct 10 1910 212 52 3703 Virginia **Director** Usual Residence of Decedent the Marylend r 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md Frederick Thurmont. 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours efter death with 1 Department of Health end Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23s or any injury or other traumatic event, the Medical Examines must be not any injury or other traumatic event, the Medical Examines must be not any injury or other traumatic event, the Medical Examines must be not any injury or other traumatic event, the Medical Examines must be not any injury or other traumatic event. 31 Colliery Drive 21788 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specity: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usuai Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) homemaker domestic 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ira Parks LaVada Fields 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) 3325 Marston Rd., Westminster MD 21157 Clarence Gibson (son) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 □ Buriai 2 □ Cremation 3 □ Removel from State
4 □ Donation 5 □ Other (Specify) Pine Grove Cemetery 1-22-99 Mt. Airy, MD 22. Name end Address of Facility 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 and. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, book or hear failure. List only one status on each line. Physician 8 YEARS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Mysardial Examiner physician and the buriel-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 80 usa 23b. Did tobacco uss contributs to the cause of death? ed by the a Part ti. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. morary artery dessure 3 Probably 4 Unknown by Page 1 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was an eutopsy Completed certificate has blirector, pege 2 s 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 28 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth 28c. injury at Work? Certification:

Attending Physician: After this ò

funeral n 24 hours after death.

• Funersi Director; After detaily filled in by the fur Hospital To the Hosp within 24 ho To the Fune completaly fi

> State Registrar

Medicai

31. Dete filed (Month, Dey, Year) JAN 2 0 1999

5 Pending

6 Could not be determined

investigation

Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature end title of certifier

29c. License number

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Dey, Year)

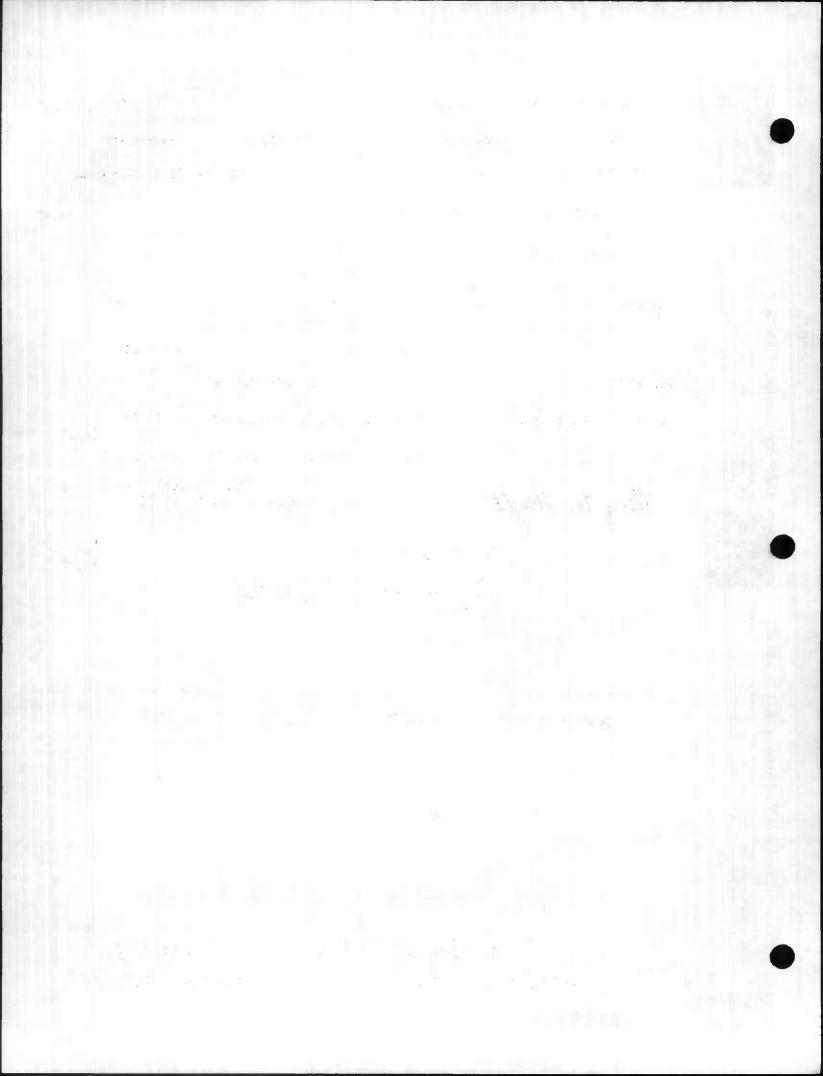
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

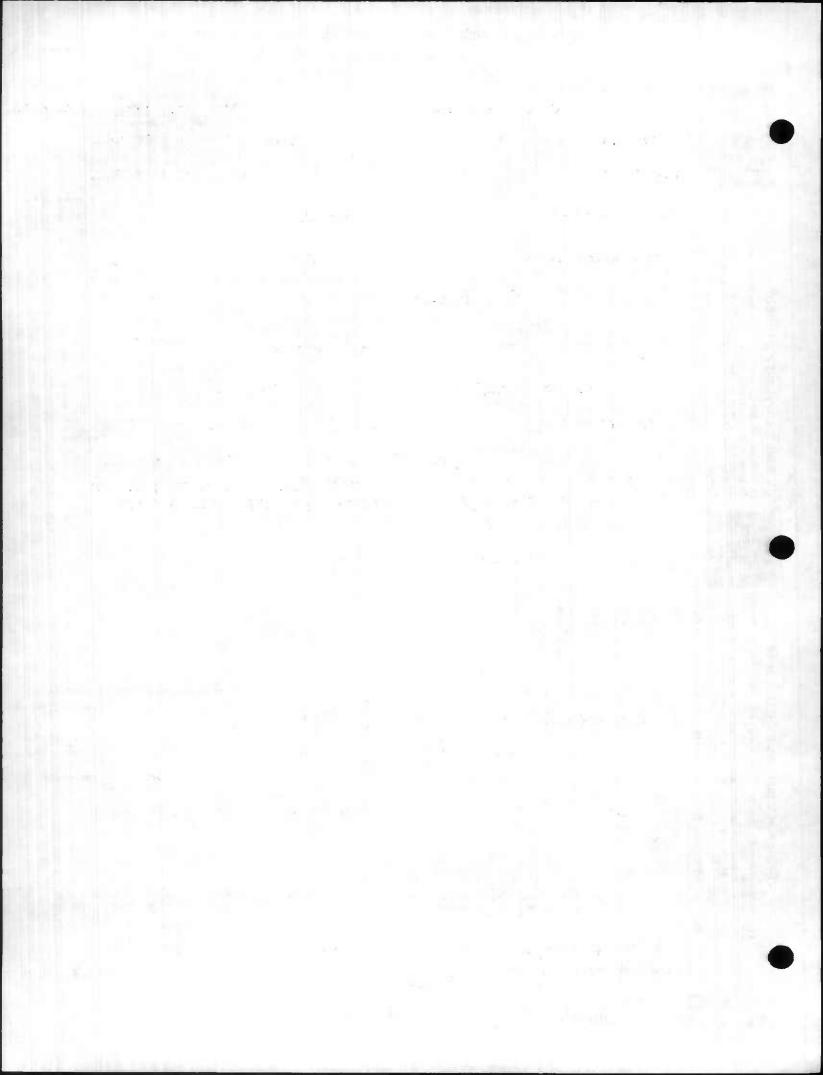
FREDERICK MJ 217

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18, Carl Graybeal Jan. 1999 7:49 a.m. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Continuum Care Sykesville Carroll If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Year 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□ F 224 18 5198 77 Yrs. Director April 13, 1921 N.C. Usual Residence of Decedent with the Maryland permit. Pages 1 end 2 should be filed within 72 hours aftar deeth with the Marylan Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show sure injury or other traumatic event, the Mod ral Examiner must be norified and 10b. County Carroll 10c. City, Town or Location 10d. Inside City Limits Md. 1 ¥ Yas 2 □ No Sykesville Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 7309 Second Avenue 21784 Funeral U.S.A. 12. Was Decedant Evar In U.S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1941-1945 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Lumber College (1-4or 5+) Saw Mill Operator 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Quince A. Graybeal Edna Ollis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kate Graybeal (spouse) 261 Klee Mill Rd. Sykesville, Md. 21784 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Park 1/21/99 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Spacify) 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) 21. Signature/of Funeral Service Licessee Sykesville, MD 21784 (410)-795-1400 Part ! Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of the control of th Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . COPD end stalo **Examiner** Examiner physician and the burial-transit death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avents resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequenca of): USe as t 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yea 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Realdence 6 Other (Specify) To 1 Yas 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1. Natural 5 Pending efter death. 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicide 6 Hospital 24 hours 29a. Certifiar 🗺 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner steted. (Check only To the P within 2 29q. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1 18 1999 MD 025112 fawaga 30. Date and apply the property of mpleted cause of death (Item 23e) (Type, Print) Baltimore MD 21208 #108 Rd Keistertown 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 1999 Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month 1999 20 10:00PM Wilbert Gardner Jan 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) Talbot Genesis ElderCare - The Pines Easton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 1₫M 2□F Deys Hours Min Yrs. 216-40-4099 84 12-03-1914 Md. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 12 Yes 2 □ No Talbot Easton, Maryland 21601 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 610 Dutchman's Lane 21601 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11. Meritel Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 B No Specify: Specify: Black If Yes, Give Yeer or Detes: 3 Widowed 4 Divorcad 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Farmer FARMING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charie Garrdner Mary Hall 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Charles Gardner (brother) 11653 Old Cordova Rd. Cordova, Md. 21625 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) New Chaple 1/26/99 Easton, Md. 22. Name end Address of Fecility 322 East Ave. Easton, Md. 21601 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) PNEUMONA

Due to (or es e consequence of): ONGESTIVE HEART FALYRE

Physician /Medical **Examiner**

attending physician and for use es the burial-transit

certificata has

efter death Director:

funeral

completely To the P within 2

or Attending Physicien:

Hospital 24 hours

that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Examiner

Physician/Medical

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/Medical

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Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be northed at

permit. Peges 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or fee any injury or other traumatic event

altimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest	c. CHRONIC Due to (MONRAY DISA	YEARS					
Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	cause given in Pert I.	23b. Did tobacco use co	ontribute to the cause of death					
				24a. Wes en eutopsy performed?	24b. Were eutopsy findings evalleble prior to completion of cause of deeth?					
				1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ NO					
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axeminer?	Hospitel: 1 Inpatient 2	☐ ER/Outpatient 3☐ D	ome 5 Residence 6 Other (Specify)							
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3 Suicide 6 Could not to determined		home, ferm, street, fector ify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)							
				e, end due to the cause(s) and murred et the time, dete and placa						
29b. Signeture end title of certifier	NIN	29	c. License number	29d. Date sign	ed (Month, Dey, Year)					

State Registrar

DANIEL

E.

DO

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

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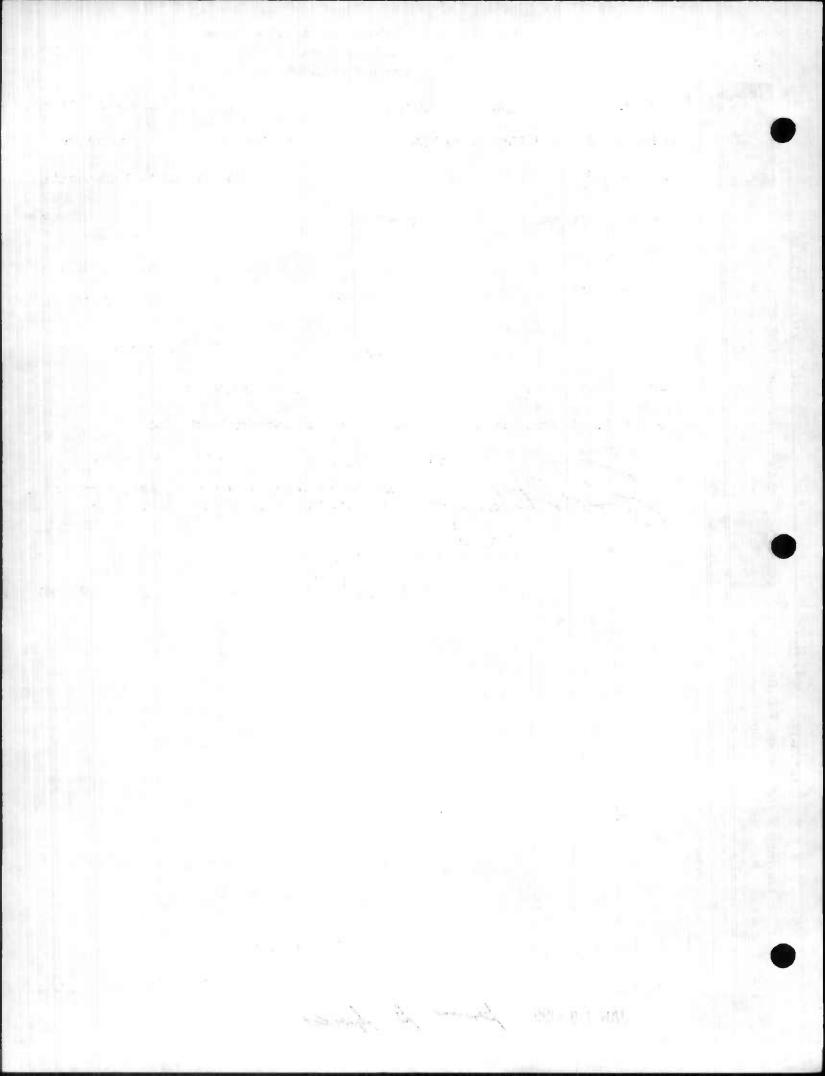
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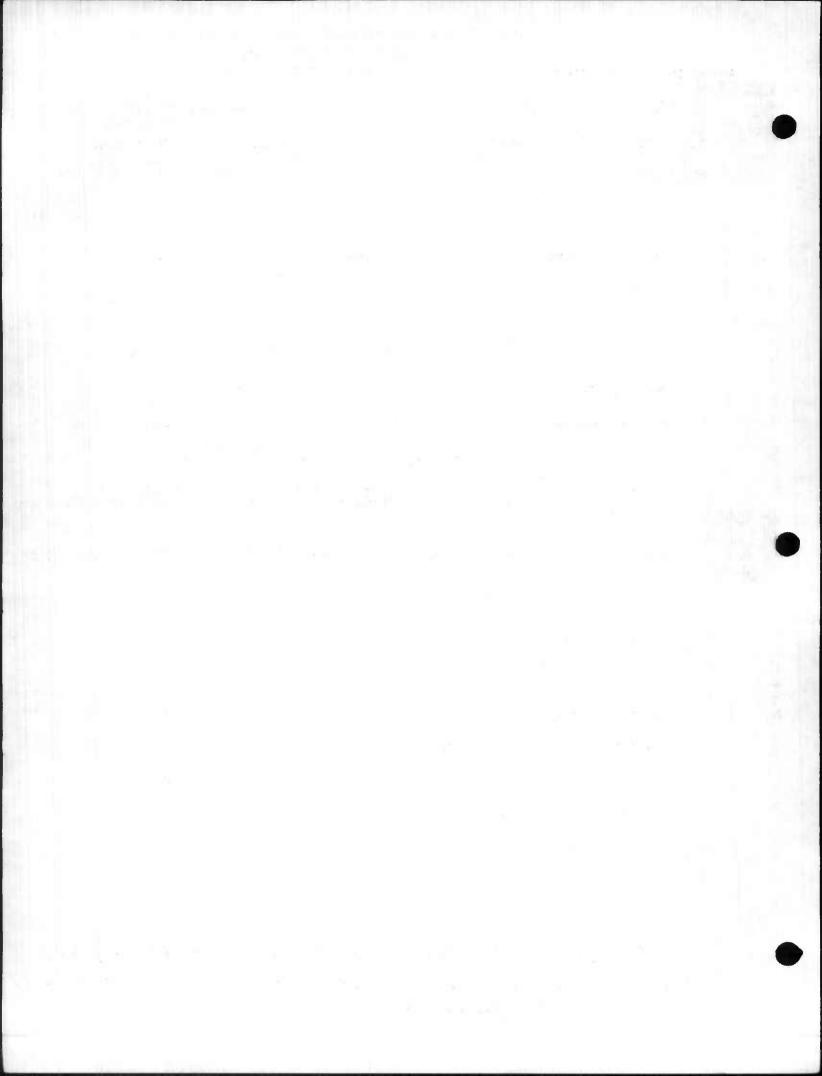
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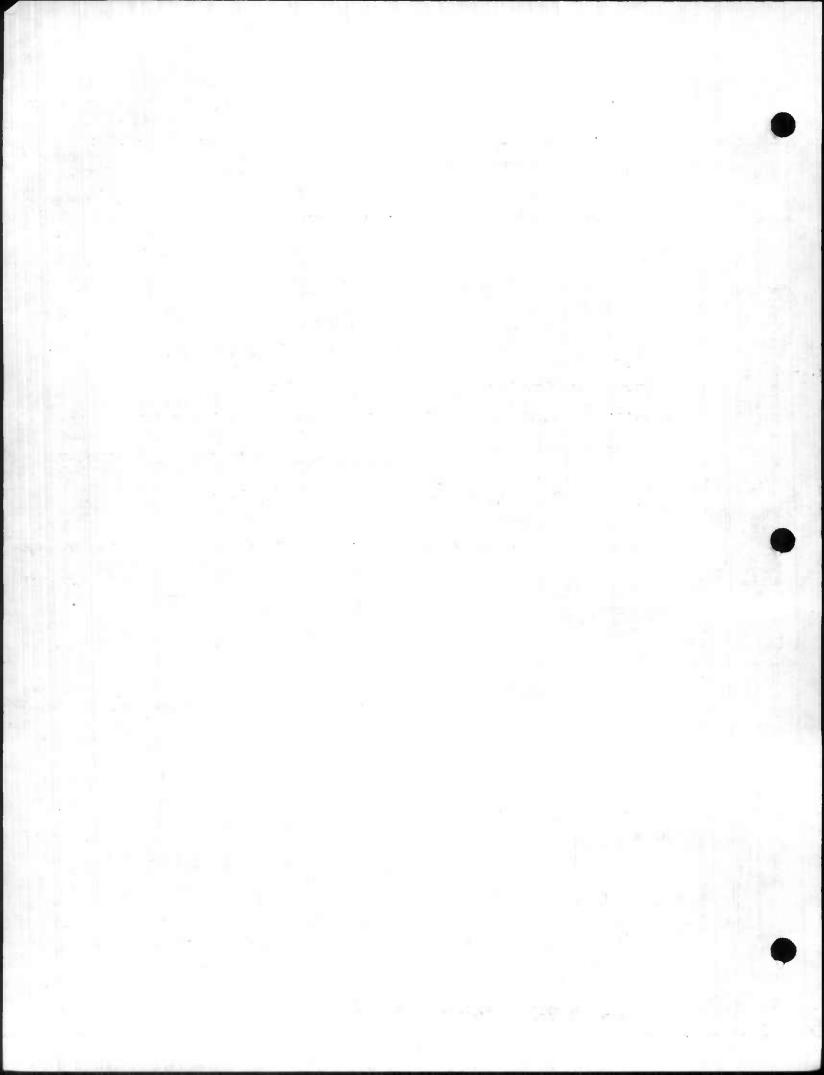
	Cei	rtificate of Death	Reg. No.	01.000						
	1. Decedent's Nama (First, Middle, Last)		2. Date of Death	3. Tima of Death						
Physicia	BARBARA JAY GIBBON	IS	January 14	999 0830						
/Medica Examine	40. Espilitu Name // not institution aircentract and cumber)	4b. City, Town, or Loc		1111						
Examine	PENINSULA REGIONAL MEDICAL CENTER	SALISB	IIRY	WICOMICO						
Farmer	5. Social Security Number 6. Sax 7. Age (In yrs. last birthday)	If Under 1 Yeer If Under 24 Hrs.	8. Data of Birth							
Funeral Director	215-74-0821 1 M 2 X F 55 Yrs. Usual Rasidance of Decedant	Months Days Hours Min.	(Month, Day, Year) November 13, 1943	Birthplaca (State or Foreign Country) North Carolina						
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21215-0020 d within 72 hours of gjene. rr then "netural", or rr then "netural", or	(Specify only highest grade completed) (Give	dant's Usuel Occupation kind of work done during most of workin DO NOT use retired)	g 16b. Kind of Bus	sinass/Industry						
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and mand		ng Address (Street end Number or Rura	Route Number, City or Town,	State, Zip Code)						
and and 27 I		Wharf Rd., Snow H	ill, MD 21863							
Baltimore, Nommir, Pages 1 and: Department of Health Important: If Item 27 any Injury or other tr	1 Burial 24 Cramation 3 Hamoval from Stata	natory or other piece)		bury, MD						
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Baltimol permit. Pages Department of Important: If it any Injury or o		2. Nama and Address of Facility Colloway Funeral Ho	me Professiona	1 Association						
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Physician /Medical	Immediate Causa (Finel disease or condition resulting in death) Dua to (or as a consect if any, leading to immediate cause. Enter Undertyling.	<u>a</u>	10 mo							
6876(ifficate be g physicia es the bur	Cause (Diseasa or Injury that initiated evants Due to (or es e consequenca of): rasulting in death) Last									
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Records, P.O. Box is less than the death cer is hes been signed by the ettending 2 should be detached for use	A paradition		24e. Wes en autopsy performed?	24b. Wara eutopsy findings available prior to completion of cause of death?						
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	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, deat of the desired of the									
To the Withir Comp	29b. Signatura and titla of certifiar	29c. License number 0 20500	29d. Dete signed	(Month, Day, Year)						
4	30. Name and address of person who complated causa of death (Itam 23a) (Type,	Print) CAPRULI SH	Smisson	mo						
State		1	VIII () () () ()	9						
Registra	JAN 1 9 1999	sporks								



Amer	nded	Item#5 per FH G773 7/2	State of Ma 0/99 EW	arylar				lealth and <i>Death</i>	Mental Hy	ygiene g	0	2560	
Physic /Medi		1. Decedent's Name (First, Middle, Last, MARY THALA)							2. Date of D Month	Day	1449	3. Time of Death 0839 A	
Exami		4a. Facility Name (If not institution, give Shady Grove Adv		Hos	pital			4b. City, Town, or Rockvil	Location of Dea	4c. County	of Death	rv	
Funerai Director		109-03-4330	7. Ag	e (In yrs. 81	last birthday) Yrs.	If Under Months		if Undar 24 Hrs Hours Min	s. 8. Data of Bi (Month, D June 2	irth (24, Year) 26, 1917	9. Birthpl Count Penns	ace (Stata or Foraigr ry) ylvania	
death with the Maryland ms 23s or 28e-f show	Director	Usual Residence of Decedant 10a. State 10b. County Maryland Montgomer	у		y,Town or Lo							0d. Inside City Limits	
th with the		10e. Street and Numbar 621 Lincoln Stree	t			10f. Zip (10g. Citizan of What Country? United States				
5 2 2	by Funeral	11. Marital Status 1 ☐ Nevar Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedant Armed Forces? 1 ☐ Yes 2 💥 I If Yes, Give Year or Dates:		1	Vas Decede FYes, speci		Ilspanic Origin? (i an, Mexican, Pue Specify:	Specify Yas or N rto Rican, etc.)	an Indian, itc. te			
Maryland 21215-0020 d 2 should be filed within 72 hours after th and Mental Hygiena. 71s marked other than "natural", or ite traumatic event, the Madical Examine	Completed	15. Decedent's Edu (Specify only highast grade Elementery/Secondary (0-12) 1.2	cation a com <i>plated)</i> Collega (1-4or 5	i+)	lifa. L	kind of worl OO NOT us	k dona a retired	during most of we		16b. KInd of 8			
Maryland 2 2 should be filled it and Mental Hygic Is marked other ir sumatic event,	To Be C	17. Father's Name (First, Middla, Last) John Barbarish						-	me (First, Middle	a, Maidan Suman		, 6016	
Para la		19a. Informant's Name/Relationship (Type, Print) Martin F. Haladay / Son 20a. Method of Disposition 1\overline{\text{MS}} Burial 2 \subseteq Cremation 3 \subseteq Removal from State} 4 \subseteq Donation 5 \subseteq Other (Specify) 19b. Meiling Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21 Meadowcroft Court, Montgomery Village, Maryland (Nama of Cematary, cramatory or other place) 20b. Place of Disposition (Nama of Cematary, cramatory or other place) 20c. Location - City or Town, Stata									valand 20886 vn, State		
Baltimor permit. Pages Department of P Important: If its any injury or of once.		21. Signature of Funeral Service License	// /	St.	Ro	Nama and	Addre Pu	ss of Facility	neral Home	Rockvill	e. Inc		
Physician /Medical Examiner	ler.	23a. Part1. Enter the disease, or comblishock, or heart feiture. List only or Immediate Cause (Final disease or condition resulting in deeth)	ACUT	EI		RIOR				FARCT	j	Approximate Inflarval Between Onset and Death	
BOX 68/60, leeth certificate be axecuted attending physicien end for use es the bunal-transit	in/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last			r as a consequ								
of the d by the letachex	Completed by Physician/Med	Part II. Other significent conditions con		ut not resi	ulting In the ur	derlying ca	use giv	en in Part I.	23b. Did tobacco use contribute to the cause of deeth				
requir	npieted b	HYPERCHOLES	TEHOLE	MIA	7				24e. Wes	s en eutopsy ormed?	ava	re eutopsy findings ilable prior to opletion of cause eath?	
E t te B	Be Con	25. Was case referred to medical examiner?						26. Place of De	1 □	Yes 2 No	1 🗆	Yes 2□No	
ng Phy ing Phy inter this	2	1 Yes 2 No H	28e. Dete of Injur (Month, Day	ν	ER/Outpatien 28b. Time of Injury		c. Injur	→ □ Hurswig		idence 6 Oth how injury occur)	
DIVISION pital or Attending urs after deeth. brel Director: After	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injubuilding, etc	. (Spacify	/)				City or To	(Street and Numb wn, Stata)			
DIVISIO To the Hospital or Attendi within 24 hours after deeth To the Funerel Director: A completely filled in by the fi	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier Au 4	Iclan: To the best der: On the basis of and mannar sta	examinal	lion and/or Inv	estigation, i	Licens	pinion, deeth occi	urred at the time,	, dete and place, 29d. Date signe	and due to d <i>(Month, E</i>	the cause(s) Pay, Year)	
		30. Name and address of person who college SEVENSOL 31. Date tiled (Month, Day, Yaar)	mpleted cause of di	· Dr	23a) (Type, I	ROCK	121	068 DR	INE #ZU	00 BETHE	SDA	1999 Neb 2081	
Sta Registr	-	JAN 2 1 1999	bene	ممم	B.	100	ul						



			Ce	ertifica	te of	Death		Reg. No.			
	1. Decedent's Name (First, Middla, Last)					2. Data of De Month		Vone	3. Time of D	eath
Physician /Medical	PIARIE D.	HALL					JAN.	16, 19	999	7:56	PM
Examiner	An English Stome (Mant Institution when	street and number)	- 4.4		-	4b. City, Town, or	Location of Death	4c. County	y of Death		
011	Holy Cross Ho	spital					Spring		TGOME		
Funeral Director	213-38-6860	7. Age (In yrs. 62	last birthday Yrs.	Months	Days	If Under 24 Hrs Hours Min		h y, Year) 1936	9. Birthpla Countr Ma	ace (Stata or i	Foraign 1d
1 1.	Usual Rasidanca of Dacadant 10a. Stata 10b. County	10c. Cit	y, Town or I	ocation					10	d. Inside City	Limits
with the Marylar a or 28e-f show be notified at	MD Montgor	mery	Sil	ver	-	ing		1 ☐ Yes 2			
ath with 1 23s or 3 sust be n						0906		U.S	.A.		
Maryland 21215-0020 42 should be filed within 72 hours after destity th and Mental Hygiene th and Mental Hygiene The marked other than "natural", or items 23 traumetic event, the Medical Examiner must To Re Completed by Funaval	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evar in U Armed Forcas? 1 ☐ Yes 2€ No If Yes, Give Yaar or Datas:	,S. 13	. Was Deci If Yas, sp 1 ☐ Yas		Ispanic Origin? () an, Mexican, Puel Specify:	Specify Yas or No rto Rican, etc.)	Bia	ce - America ck, Whita, at y: Bla	tc.	
od within 72 ho ygiane. or than 'natur. t, the Medical.	15. Decedent's Edu (Specify only highast grad	cation a completed)	16a. Dec	edent's Usi a kind of w	ual Occup	ation during most of we	orking	16b. Kind of B	usiness/Indu	istry	
121	Elementery/Secondery (0-12)	College (1-4or 5+)	Giva kind of work don lifa. DO NOT use retir					11 0			
S Paris			Pe	ELSON	mer		me (First, Middle,			rnmen	it
Banda ag	6	carion						Maiden Sullai	na)		
Tyle Mend	19a. Informant's Name/Ralationship (T)		100 100	tion Address	(04		l Lee	Ch Tour	Crete 7in f	Codel	
E = 74 L	Granville G. Ha	all (Husban	d) 2	2411	Bel		., Sil	er Sp	ring,	MD 2	2090
Saltimore, semit. Pages 1 ar Separtment of Hose reportant: If New my Injury or othe alice.	20a. Mathod of Disposition 1 Burial 2 Cramation 3 F 4 Donation 5 Other (Specify)	lamoval from Stata	Place of Disp cematary, ch rklaw	ematory or	other plac		Deta 1/22/9	20c. Location Roc]		m, Stete)
Balt permit. Departr imports any lelk ance.	21. Signature of Funaral Sarvice Licenses 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850										
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Physician	shock, or haert tailura. List only of		Onset and								
/Medical	Immediata Causa (Final disaasa or condition rasulting In death) METHSTATIC BREAST CANCER Dua to (or as a consequence of):										VTIS
Examiner											
		550.10 (1		9901100 01							
58760, cate be associted physician and the burial-transit addical Examiner	Sequentially list conditions, if any, leeding to immadiata cause. Entar Underlying Cause (Diseesa or Injury	Dua to (c	r as a conse	onsequence of):							
fificate be any physician as the burian	rasulting in daath) Last	Dua to (c	r as a conse	equenca of)	:						
Box eath cert attendin Ifor use		l									
od fo	Part II. Other algnificant conditions cor	tributing to death but not ras	ven in Part I.	23b. Did	tobacco uae co	ontribute to	the cause of	death?			
15, P.O. BOX res that the death ce signed by the attendit be detached for use by Physician/							10	Yea 2010	3 Probe	ebly 4□U	nknowr
requirements							24a. Was perlo	an autopsy med?	com	re autopsy fin ilable prior to apletion of car eath?	
The law ete has page 2							10	ras 20 No	10	Yas 2□ N	No
Vital I	25. Wes casa rafarred to medical					26. Place of De	eth (Check only o	-	1		
	1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatio	ent 3 D	OA Oth	200	Homa 5 ☐ Resid		her (Specify))	
9 Phyr er this veral d		28a. Data of Injury (Month, Day Year)	28b. Tima		28c. Injui Wor		_	now injury occu			
atio	1. Netural 5 Pending 2 Accident invastigation	(WORKIN, Day 1 bar)	Injury	М		Yas 2 □ No					
DIVISION C bal or Attending P is after death. at Director: After t ed in by the funera Certification:	3 Suicida 6 Could not be datarmined	28e. Plece of Injury - At h building, atc. (Specif	oma, farm, s	treet, facto	ry, office	•	281. Location (: City or Tox	Street and Num vn, Stata)	ber or Rural	Routa Numbe	ΘΓ,
Division of To the Hospital or Attending Physicial 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier 12 Certifying Physical Check only 2 Medical Examination	alclan: To the best of my kno ner: On the basis of examine and manner steted.	wledge, dea tion and/or i	nvestigatio	d at the tir n, in my o	ma, data and place opinion, death occ	e, and due to the curred at tha tima,	cause(s) and m data and placa,	annar as sta and dua to i	ited. the cause(s)	
Me of the	29b. Signatura and titla of certifiar	Market State (1997)		29	c. Licens	e number		29d. Deta signe	ed (Month, D	Pay, Year)	
11	Chilie lypyn	I, M.D.				AND L	942452	17 JAN	JUNZ	1 199	39
10	30. Name and address of person who co		23a) (Type								
				4327	,0	LNEY,	MD 208	32			
State Registrar	1811 1 0 101	32. Raystrar's Signa	ture 4		no s	41					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Month KOY Damue 8:30AM 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE NURSING HOME Towson Baltimore 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Days Hours 1⊠M 2□ F Yrs. 065-03-2225 83 July 4, 1915 New York State Usual Rasidance of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1X Yas 2 □ No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7001 North Charles Street 21204 United States 12. Was Decedant Evar in U,S. Armed Forcas? 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: WW II Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 🖾 No Specify: Specify: 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 National Security Agency 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Zog Samue1 Hall Pauline 19a. tnformant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Routa Number, City or Town, Steta, Zip Code) 1592 Merryweather Dr., Bethlehem, Pa.

20b. Place of Disposition (Name of cematary, cramatory or other place)

Data

20c. Location - City Thomas Roy Hall 18015 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Fort Lincoln Crematory 1/18/99 Brentwood, Maryland 21. Signature of Fungral Service Licentific 22. Nama and Addrass of Facility Hines-Rinaldi funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Md. 20904 23a. Part1. Entar tha hisaasa, or complications that causad the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or heert failure. List only one ceuse on each line. Immediata Causa (Finel disaasa or condition rasulting in daath) Due to (o Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or trijury that initiated avents rasulting in daath) Last Dua to (or as a consequance Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Winknown 1 ☐ Yee 2 ☐ No 24b. Wara autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performad? 260 No 1 Yes 25. Was casa rafarred to medicat 26. Place of Deeth (Check only ona) Othar: 4 Nursing Homa 5 ☐ Rasidenca 6 ☐ Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Menper of Death 28a. Data of injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 1 Naturel 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 3 ☐ Sulcida 28a. Place of Injury - At homa, farm, straat, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 I Homicida

P.O. Box 68760, Records, Division of Vital

physician and s the burial-transit The law requires that the death certificate be executed attending for usa as signed by the a cartificata has lirector, page 2 s tal or Attending Physician: These star death.

It Director: After this cartificate of by the funeral director, ps Hospital 24 hours

Physician/Medicai þ Be Completed Certification: To

Examiner

Physician

Examiner

Funeral

Director

ns 23a or 28a-f show

Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hydlena. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Exercises once.

Physician /Medicai

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

/Medical

To the Mosp within 24 hot To the Fune complataly fi

State Registrar

Medicai 29b. Signatura and title of o 9c. Licansa number 29d. Data signed (Month, Dey, Year) 30. Name and add person who complated se of daath (Itam 23a) (Type, Print) WO (Month, Day, Year) 31. Data Registrar's Signatura 1999

JAN 20

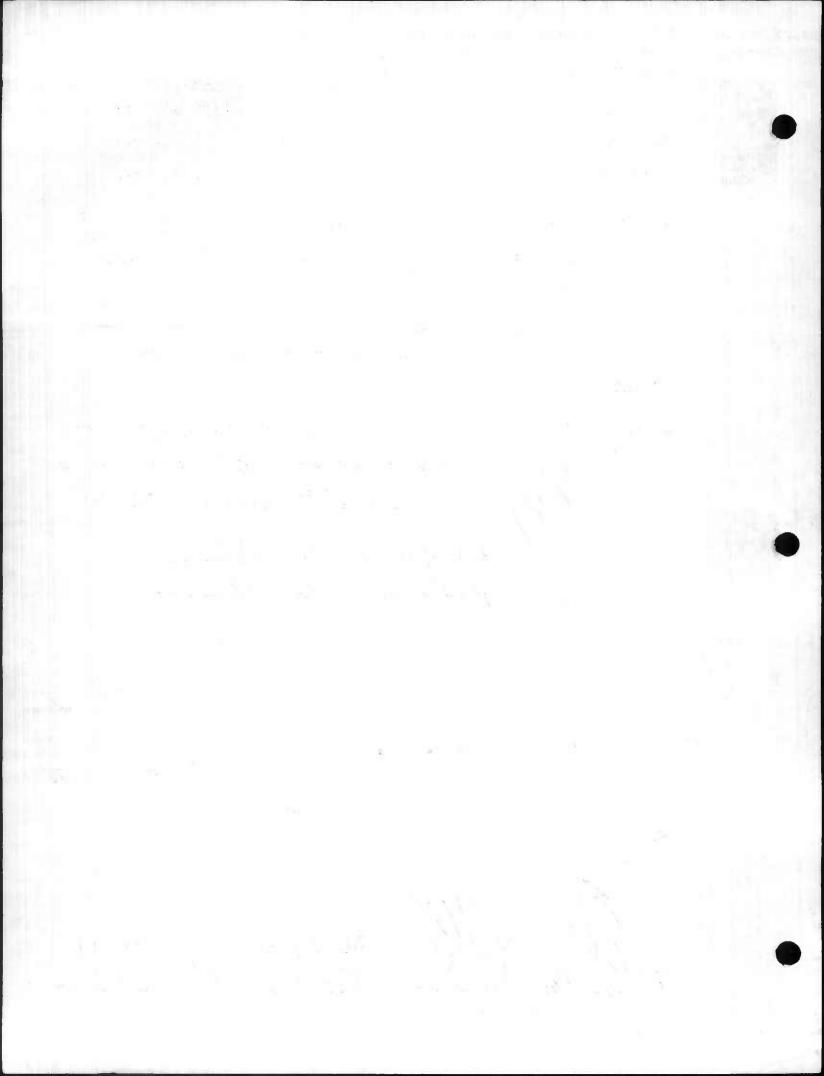
29a. Certifiar

ntner: On the basts and manner

Furth ring Physician: To the best of my knowledge death occurred at the time, data and pleca, end due to the cause(s) and menner es steted.

Medical Example: On the basts of example item and of invastigation, in my opinion, death occurred at the time, dete and piece, and due to the o

invastigetion, in my opinion, death occurred at tha time, dete and piece, and due to the ceuse(s)



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1, Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year **Physician** January 15, 1999

4b. City, Town, or Location of Death 4c. County of Death Kum N. Han 5:10 am /Medical 4a Facility Name (If not institution, give street and number) Examiner Bethesda ar | H Under 24 Hrs. ys | Hours | Min. Suburban Hospital Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 2☑ F Director 226-11-5880 Sep. 8,1914 Korea Usual Residence of Deceden the Maryland 10e. State 10b. County 10c. City. Town or Location 10d. inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mental Hyglena. Important: If Item 27 Ia marked other than "natural", or Itema 23a or 28a-1 show any injury or other treumatic event, the Medical Examinar must be notified. 1 ☐ Yes 2 € No Director Maryland Montgomery Bethesda 10a. Street and Number 10f. Zio Code 10c. Citizen of What Country? 10250 West Lake Drive #101 Funeral 20817 U.S.A. 14. Rece - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☑ Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2K No Specify: Specify. py 3 ☐ Widowed 4 ☐ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18 Mother's Name /First Middle Maiden Sumame 17. Father's Name (First, Middle, Last) Be 2 Kee S. Na Choon Chung 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bethesda, Maryland 20817 Kyung C. Han (husband) 10250 West Lake Drive #101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Norbeck Memorial Park 1/18/99 Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 23a. Part. Enter the disease, or complications that children's the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

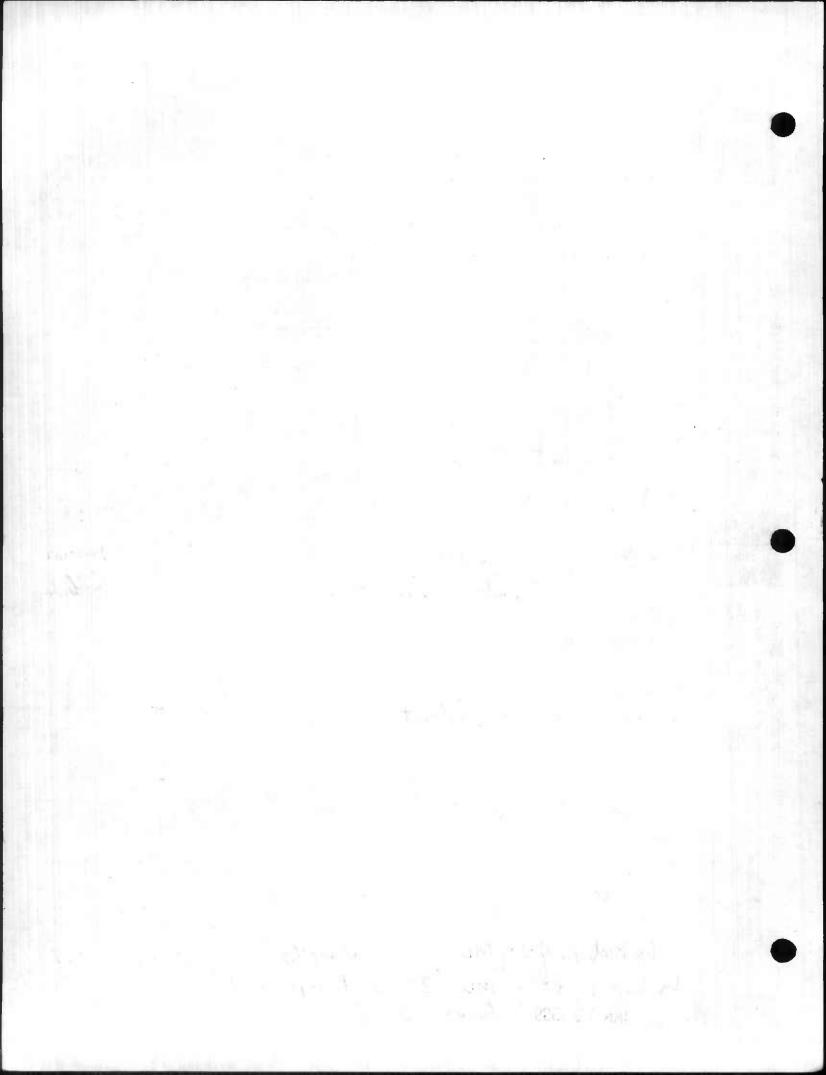
Approximate Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final month disease or condition resulting in death) Examiner Examiner hysicien and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dig to (or as a corts Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by 1 | Yea 2 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 988 page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After 1 Divetural 5 Pending investigation death. 1 | Yes 2 | No To the Hospital or Attendivithin 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only 29b, Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUP MO 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

Registrar

JAN 19

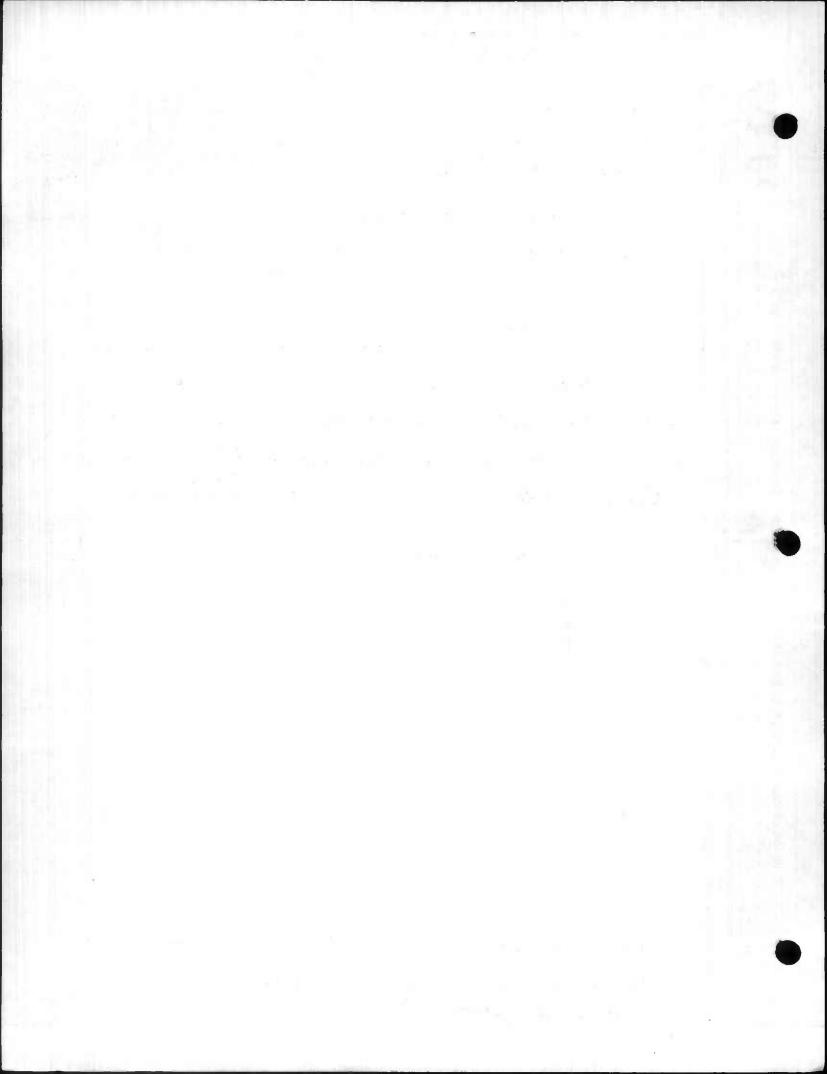
1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 5 6 4

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		1. Decedent'a Nam	a (First, Middla, Le	ist)							2. Data of De	eath			. Time of Death
Physici Medid		Thomas	Wayne Ha	rman							Month Januar	y 12,		9 8	:16am
Examir		4a. Facility Nama (If not institution, gir	a street and nu	m <i>ber</i>)				4b. City, Tov	wn, or Lo	ocation of Deat	-	ounty of [· · · · · ·
LAGIIII	ICI	Montgon	nerv Gene	ral Hos	nital				Olne	2.57			ntgo		
.maual		5. Social Security N		Sax	7. Aga (in yrs	. last birthday	ff Under	r 1 Year	If Under 2	2	8. Data of Bi	rella	1,0	-	(State or Forein
uneral rector		214-62-4		1∭ M 2□ F	4		Months	Days	Hours	Min.	Feb. 1,	1 953	7.7	Country)	i (Stete or Foreig irginia
		Usual Rasidance o							<u> </u>		100.1,	1733	W	est v	riginia
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i g			ied 21 Marriad	1 ☐ Yas If Yes, Gi	2 🖾 No		1 🗆 Yas	2 🕅 No	Specify:			9	pecify:	Whi	to
	d by	3 Widowed	4 Divorced	Yaar or D	atas:			11					poony.	WILL	
	Completed	(Snec	15. Decedent's E	ducetion		16a. Dece	dant's Usu	ai Occup	etion	t of work	ina	16b. Kind	of Busin	ess/Indust	ry
Die Min	aldr	Elementary/Seco		Collaga (1-4or 5+)				during most		# <i>1</i> 9	_			
	lo.	12			,	Gener	al Su	iper:	Intend	lant		En	cava	tion	
	Be	17. Fathar's Nama	(First, Middla, Last)					18. Motha	r's Nam	a (First, Middle	, Maiden S	umama)		
	ToB	Ellswort	h Harman	*					Neva	ı Lu	cille H	inkle			
	-	19a. Informant's No	ame/Ralationship	Type, Print)		19b. Maili	ing Addrass	s (Streat	and Numbe	er or Rur	al Routa Numb	er City or	Town Sta	ta Zin Co	n(a)
É			. Harman				_				aithers				*
permit. ragges i end z should Department of Health and Mer important: If Item 27 is marke eny injury or other traumatic once.		20e. Mathod of Dis		()	20h	Place of Disp				T					
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		4 Donetion	5 MOthar (Speci	wIntomb	ment (late of					1999				, Ma.
Depart import eny in		21. Signature of Fu	ınarai Sarvice Lica	nsee		2	2. Nama er	nd Addre	ss of Fecility	y De	Vol Fur	eral	Home		
a		Curl	IN C.	Lay		1	0 Eas	st De	eer Pa	ark 1	Dr. Gai	thers	burg	, Md.	20877
		23a. Part1. Enter t	he disaasa, or com	plications that	aused tha daa	th. Do not an	tar tha mod	da of dyin	o, such as	cerdiec	or respiratory a	rrest.		Ap	proximete
an		shock, or haa	rt failure. List only	one causa on a	ach lina.										arval Between sat and Death
an		fmmediete Cause	(Final												
ner		disaasa or condition resulting in death)	on									Days			
	_			Due to (or as a consequance of):											
ē l					200 10 (or as a conse	quance of):	,						Ī	
nsir nlne	ale e			b		or as a conse	quance of):								
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	I Examiner	Sequentially list co if any, leeding to in ceuse, Entar Unda Causa (Disease or	inditions, nmadiata triving	b		TIECH ON								1	
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0	Physiclan/Medical	rasulting in daeth)	Lest	cd	Due to (or as a consec	quanca of):	:	en in Part I.			tobacco us			
Ben IOI Dell'agino ec	by Physiclan/Medical	rasulting in daeth)	Lest	b	Due to (or as a consec	quanca of):	:	en in Part i.		1	Yee 2□	No 3[Probabl	y 4∰Unknow
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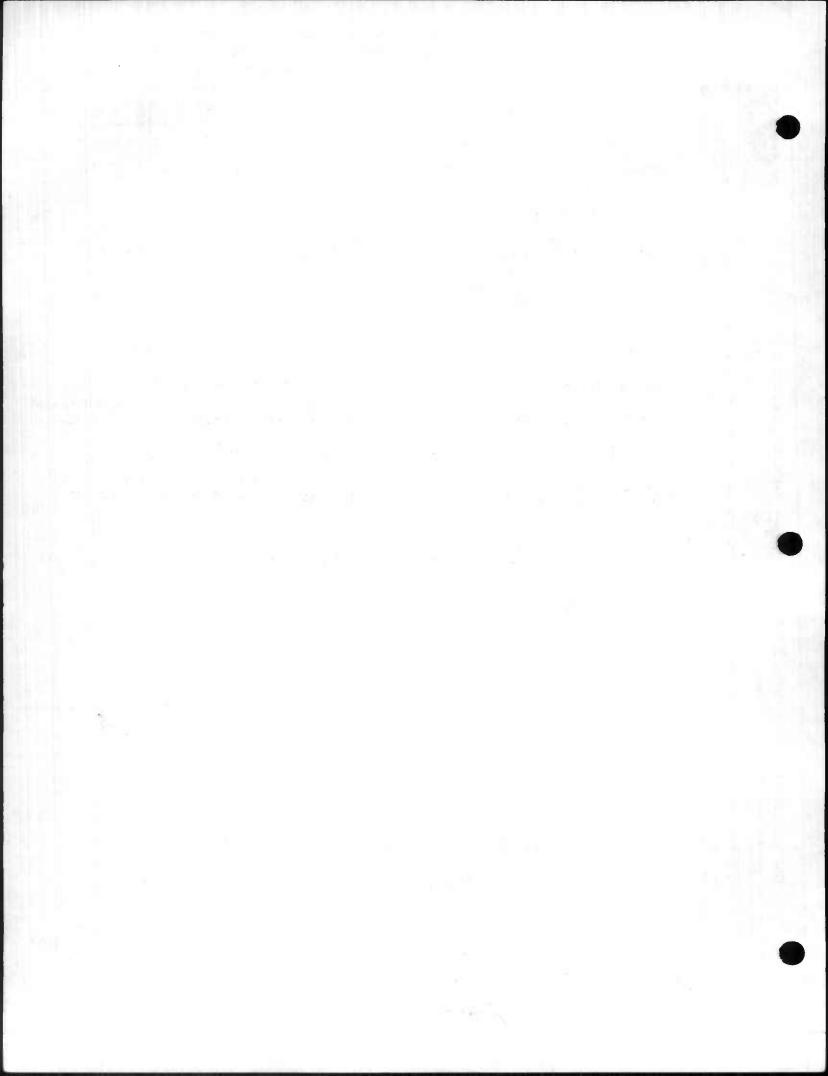
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 17, 1999 MICHAEL JOSEPH HARMON 10:55am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville, MD Montgomery 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 9, 1961 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1∭M 2□F Days 37 Yrs. 231-04-1524 Director Wash. D.C. Usual Residence of Decedent the Marylend 10a, Slale 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or items 23a or 28s-1 show any Injury or other traumatic event, if a Maplical Examination must be notified a Md. Montgomery Montgomery Village 1 Tyas 2K No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 18351 Lost Knife Circle 20886 United States Funeral 12. Was Daceden! Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Surname) Be William Joseph Harmon Mary Ellen Price 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 20386 Mary Ellen Price (Mother) 18351 Lost Knife Circle Montgomery Village, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 19 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 1999 21. Signature of Funeral Sarvice Liceral 22. Name and Address of Facility DeVol Funeral Home wites 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) Narcotic Examiner Due to (or es a consequence of): physician and the burial-transit Sequentially list conditions, it any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) attending ŏ signed by the all d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were sutopsy findings available prior to completion of causa of death? should should 24a. Was an autopsy performed? Completed certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitel: 1 Inpatient 2 ER/OutpatienI 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: After Attanding Injury Unknowm 5 Pending invastigation 1 Natural unknown al or Attanding after death. December 31, 1998 1 Yes 2 No 2 Accident filled in by tha Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, \$tate) 4 T Homicide To the Hospital o within 24 hours af To the Funeral Di unknown unknown 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier pletaly 29b. Signature and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) $\mathcal G$ doeth (Hem 23e) (Type, Print) | 11/40 Rockville Pike, #348, Rockville, MD 20852 omsko, State

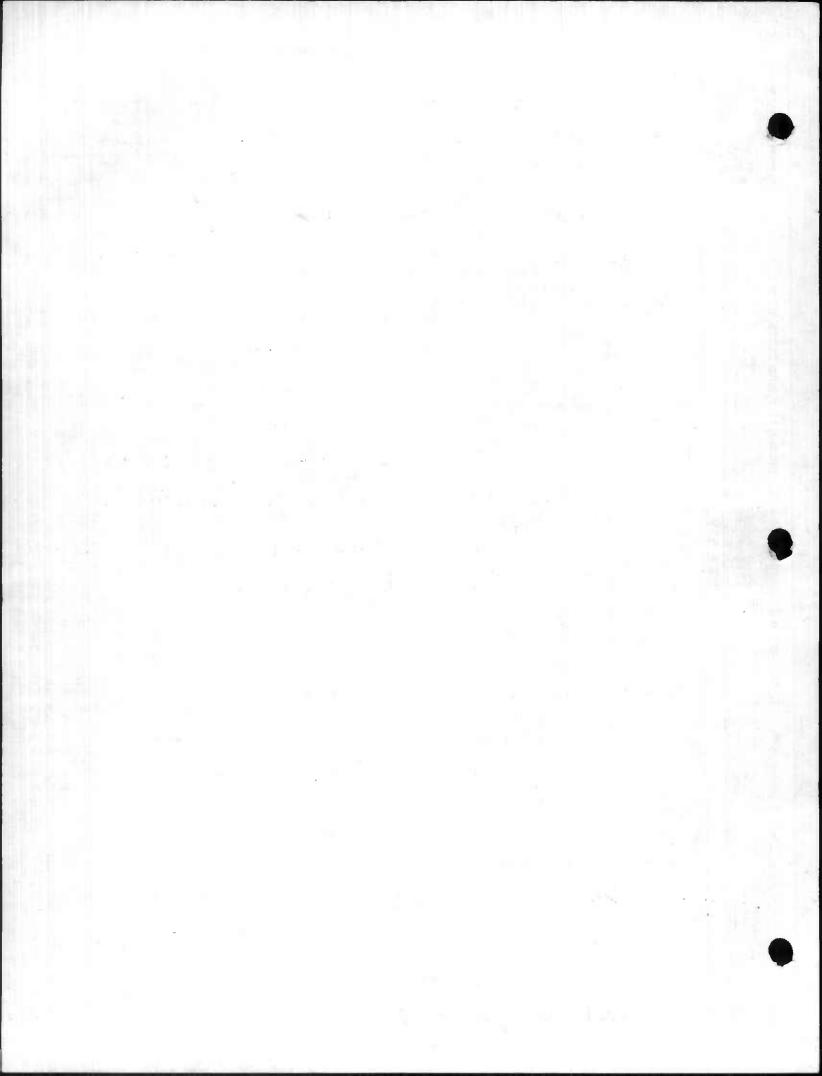
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 5 6 6

			Certificate of	Death	Reg.		2000		
	1. Decedent'e Name (First, Middle, Last)			2	Date of Death Month	Dev Year	3. Time of Death		
Physician /Medical	WILLIAM ODELI	HAY	WOOD	J	ANUARY	12, 1999	1705		
Examiner	4e Facility Neme (If not Institution, give street and Montgomery General H			4b. City, Town, or Local Olney		4c. County of Death Montgome			
Funeral Director	5. Sociel Security Number 245-12-8177 6. Sex 1 M 2 0	7. Age (In yrs. last	birthday) If Under 1 Yea Months Days	s Hours Min.	Date of Birth (Month, Day, Ye Oct. 31,	ar) Cou	hplace (State or Foreign unity) NC		
2 .	Usuel Residence of Decedent 10a. Stete 10b. County	10c City To	own or Location				10d. Inside City Limits		
the Marylar 28a-f show notified rector	MD Montgomery		ilver Spring				1 Styles 2 □ No		
ath with the Mains of 23s or 28s-fs	10e. Street and Number 2602 Squaw Valley Co			2096	U	citizen of What Cou	ites		
5-0020 72 hours after death with the Maryland natural; or thems 23e or 28e-f show seal Examiner must be notified at setel Examiner must be notified at sted by Funeral Director	1 Never Merried 2 Married 1X Y	Decedent Ever in U.S. I Forces? Des 2 No Give Or Detes: 1943/4	1 Von 200 N	Hispanic Origin? (Specifican, Mexican, Puerto Ricon) Specify:	y Yes or No- an, etc.)	14. Race - Amer Bleck, White Specify:			
72 hours	15. Decedent's Education (Specify only highest grade complet		Sa. Decedent's Usual Occi (Give kind of work don	upation e during most of working	16b	. Kind of Business/I	ndustry		
2121 I within ione. then the k		e (1-4or 5+)		e during most of working ed) 1 Service		Cleaners			
and 2 be filed hall Hygiel event, by	17. Father's Neme (First, Middle, Last)		_	18. Mother's Name (I	irst, Middle, Maid	den Surname)			
Maryiand d 2 should be file d 2 should be file th and Mental Hy T is marked othe treumatic svent To Be C	Lee Haywood			Gertrude	Darr				
Maryid d 2 should th and Mer 7 le marks treumatic	19a. Informent's Neme/Retetionship (Type, Print)	et and Number or Rural F							
	Sheila O. Fitzgerald		2602 Sqaw C						
	20a. Method of Disposition 1 ☐ Burial 2X Cremetion 3 ☐ Removel fr 4 ☐ Donetion 5 ☐ Other (Specify)	JIII State	of Disposition (Name of stery, cremetory or other pi sapeake Cremi		Date 20c	Beltsvil			
Baltimo permit. Pages Department of Important: If It eny Injury or pages.	21. Signeture of Funerel Service Licensee	ans, Inc.							
	23a. Pert1. Enter the disease, or complications the shock, or heart feiture. List only one cause	at caused the death. D	O not enter the mode of d	ring, such as cardiac or r	espiratory errest,	DC, 2001	Approximate Interval Between Onset and Death		
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)		in Lobe a consequence of: A	zo tem	omia	- I	2 Weeks		
rificate be rificate be ng physicia as the burnel Medical	Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of):								
death death death death different di	Pert If. Other algorificant conditions contributing (o death but not resulting	a in the underlying cause of	niven in Pert I	23b. Did tobac	cco use contribute	to the cause of death?		
P.O. de by the detachy	Hypercalce	mia	g in the throughput cause y			2□No 3□Pr	* 4		
ecords, P.O law requires that the ss been signed by th i.2 should be deteche hpleted by Phys	Hypernats	emia			24a. Wes an a performed	17	Were autopsy findings evailable prior to completion of cause of death?		
The page	Uninany T	ract]	nfeetin	~	1 ☐ Yes	1	1 Yes 2 No		
Vital I victor: The contilicate rector, pag	25. Wes case referred to medical examiner?			26. Place of Death (Check only one)				
on of sing Physical Affer this funeral di	1L Tes 200No	ate of Injury fonth, Day Year)	b. Time of Injury 28c. In		5 Residence d. Describe how i	e 6 Other (Speciniury occurred	oify)		
Division C To the Hospital or Atlanding P within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be	ece of Injury - At home ilding, etc. (Specify)	, ferm, street, fectory, offic	е 28	f. Location (Stree City or Town, S	nt and Number or Ru Mate)	ıral Route Number,		
he Hospit in 24 houn he Funera pletely fille edical (29e. Certifier (Check only one) Certifying Physician: To 2 Medical Examiner: On the and r	the best of my knowled e basis of examination renner steted.	dge, death occurred et the and/or investigation, in my	time, date and place, en r opinion, death occurred	d due to the caus at the time, date	e(s) and menner as and place, and due	stated. to the cause(s)		
withi To the commo	29b. Signeture and title of certifier William	I-Nin		45285 1#1/3 Si		Date signed (Month	12, 1999		
	30. Name and eddress of person who completed of WF Ninaa, 34	4 Univer	7	, 113 , Si	lver s	ping,	md.		
State Registrar	31. Dete filed (Month, Dey, Year) 3	2. Registrar's Signature	4 1	est 1					



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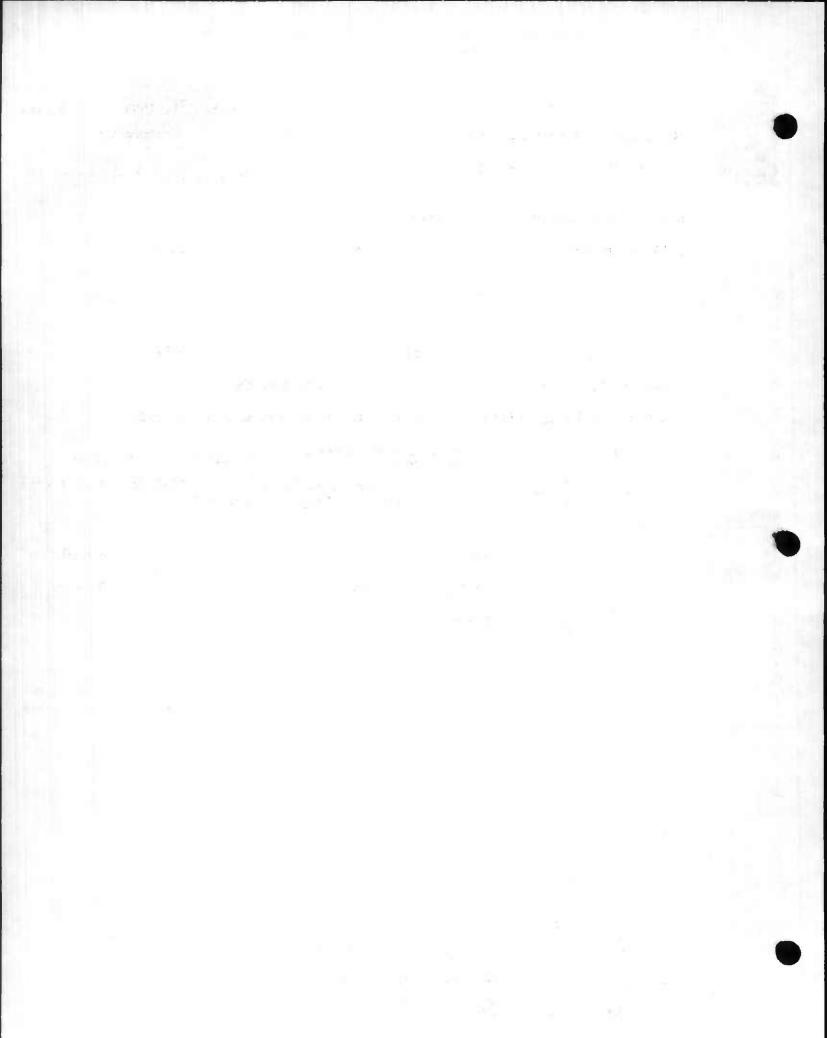
Department of Health An Certificate of Death 1. Decedent's Neme /First, Middle, Last 2. Dete of Deeth 3. Time of Deeth **Physician** Month Rita E. Van Horn 17, 1999 8:15 p.m. January /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Carriage Hill Nursing Home Bethesda Montgomery If Under 1 Yeer If Under 24 Hrs 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours 579-05-7851 1□ M 25 F 82 Yrs Director Jan. 1, 1917 Washington, DC Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Bethesda 1 X Yes 2 □ No Maryland Montgomery Directo 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? deeth with 20814 5215 Cedar Lane U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Meritel Stetus should be filed within 72 hours effer ond Mental Hygiene. marked other than "natural", or Her 1 5₹ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education ify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest g Elementery/Secondery (0-12) College (1-4or 5+) Staff Manager AT&T permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked other any injury or other traumatic event. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Albert C. Van Horn Ava Gascoigne To 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1127 Putter Path, Orangeburg, SC 29115 Jan Van Horn Wells Niece 20b. Plece of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, Stete Baltimore/Washington Crematory 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State 1/25/99 Laurel, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) of Funerel Service Licen Joseph Gawler's Sons, Inc, 5130 Wisconsin Avenue N.W., Washington, D.C. 20016 , or complications thet caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, List only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** /Medicai Immediate Ceuse (Finel Sepsis 2 weeks disease or condition resulting in deeth) Examiner Due to (or es e consequença of) Examiner Parkinson's Disease 8 years burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events Due to (or es a consequence of): pue physician e Alzheimer's Disease Box 68760. 8 Physician/Medical thet initiated events resulting in deeth) Lest Due to (or es e consequence of): attending 980 detached for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. the 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 Yee 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? pege 2 certificate 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) e Hospital or Attanding Pi 124 hours efter death. a Funeral Director: After th 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 1 X Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident pletely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homlcide To the Hospital of within 24 hours e To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 99 D35579 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Susan J. Miller, M.D. 6844 Tulip Hill, Bethesda, MD 20816 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State

souls

DHMH 16 Rev 6/95

Registrar

JAN 2 2 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 21, 1999 January 3:20 AM Yun-Qun Hung 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 20, 1920 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months 1 M 2 D F 78 Yrs China 213-88-8266 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 Rosemere Avenue 20904 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Yak Man Hung Pui Fong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Ting Yau Hung (wife) 609 Rosemere Avenue, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 図 Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 1/23/99 Silver Spring, MD

Silver Spring, MD 20901

Physician /Medical

permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any injury or other traumatic even

Physician

/Medical

Examiner

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Director

Funeral

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Examiner

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Certification: To

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29a. Certifier

(Check only one)

29b. Signature and fitte of certifier

21. Signature of Funeral Service License

Funeral

Director

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Baltimore, Maryland 21215-0020

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Examiner

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The law requires that the death certificate be axecuted

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al

Immediate Cause (Final disease or condition rasulting In daath) CONGESTIVE CARDIOMISPATH Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadsa on each line.

Approximate Interval Between Onset end Death

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No 1 🗆 Yas

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Certifying Phyeician: To fha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stafed.

22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West

29c. License numbe 29d. Dete signed (Month, Day, Year)

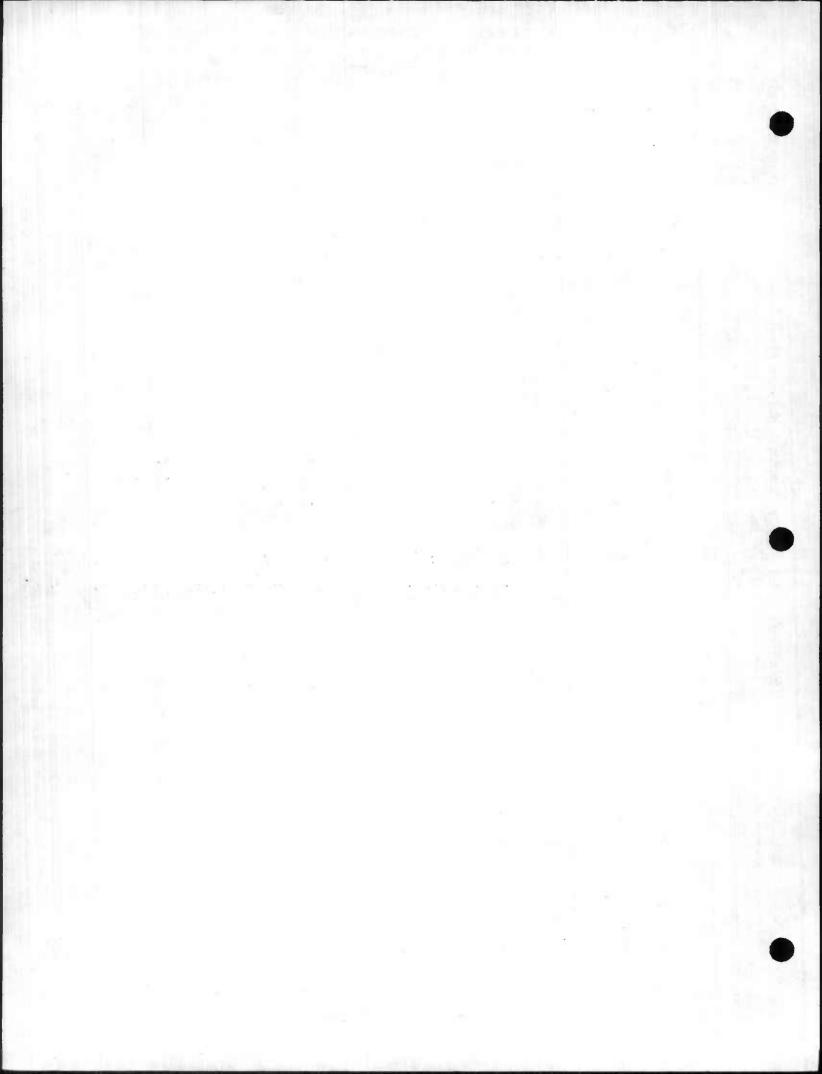
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan I. Kermaier, M.D., 10313 Georgia Avenue, Silver Spring, MD 31. Date filed (Month, Day, Year)

State Registrar

JAN 2 2 1999

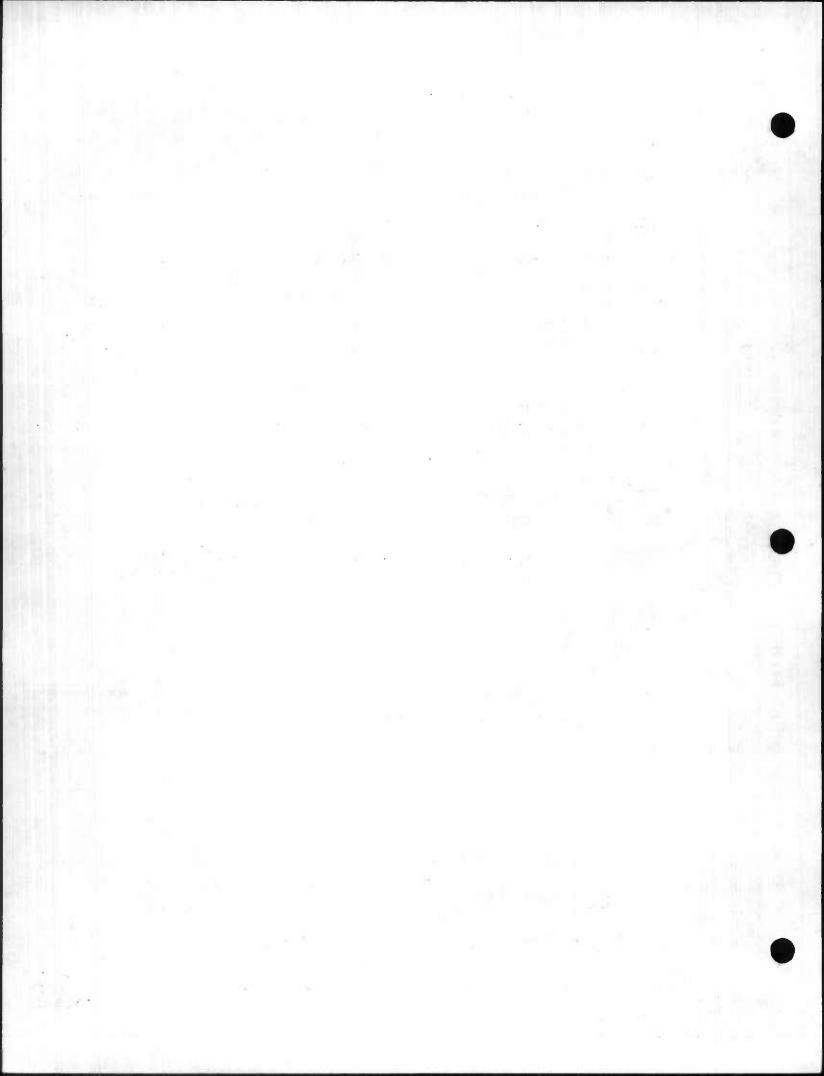
32. Registrar's Signature



	State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 5 6 9 Certificate of Death Reg. No.
Physician /Medical	1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Year Year Year Year Year Year Year Year
Examiner Funeral Director	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death ALUCE GEOLGES 5. Social Security Number 213-74-3996 6. Sex 7. Age (In yrs. last birthday) 1 Months Deys Hours Min. 92 Yrs. 4b. City, Town, or Location of Death ALUCE GEOLGES 6. Sex 7. Age (In yrs. last birthday) Yrs. 4c. County of Death ALUCE GEOLGES 9. Birthplace (State or Foreign County) County) 9. Birthplace (State or Foreign County) County) 1 January 19, 1906 Maryland
with the Maryland a or 28=4 show be notified at	Usuat Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Charles Waldorf 12√Yes 2□No
tar death in them 23 in the man	10e. Street and Number 2004 Amberleaf Place Apt.T-3 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 11. Merital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 3 IXWidowed 4 Divorced 10g. Citizen of Whet Country? U.S.A. 11. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Yes 2 INO Specify: Specify: Black
15.	SECTIONS TO DIVOCOL TEST TO Dates:
re, Maryland 212 s 1 and 2 should be filed within thath and Mental Hygiena. than 27 is marked other than other traumatic avant, the M	17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme)
Page Page nent of int: If	Alice Henson/Daughter 2004 Amberleaf Place Apt.T3 Waldorf Md 20602 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetery or other place) Resurrection Jan. 22,99 Clinton, Md
Baltim permit. Pag Department Important: I any injury o	21. Signature of unual Service Licenses 22. Neme end Address of Facility Adams Funeral Home P.A. Aquasco, MD 20608 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate
Physician /Medical Examiner	shock, or heaffeilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Interval Between Onset and Deeth CALIXOVASCUM List only one cause on each line. Interval Between Onset and Deeth CALIXOVASCUM Due to (or as a consequence of):
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P.O. detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25th 3 Probably 4 Unknown
aw requires to the second of t	DEGIDIATION 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
f Vital yalden: T s confficet director, pt	25. Was case referred to medical examiner? 1
Olvision or Attending after death. Director: After in by the tune ertification	27. Manner of Death 1 bletural 2 Accident 3 Suicide 4 Homicide 28. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work? 1 Yes 2 PANO 28d. Describe how injury occurred
To the Hospital within 24 hours To the Funeral completely filled Medical C	29a. Certifier (Check only one) 1 Ecrtifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Description on the basts of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Description on the basts of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Description on the basts of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
D + 3 + 8	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
State Registrar	P. WISOTTY MD. (ZOTO DID LINE CENTER WALDORF, Nd 31. Date filed (Month, Day, Year) 32. Registre's Signeture S. Joannes S. Joannes

Registrar DHMH 16 Rev 6/95

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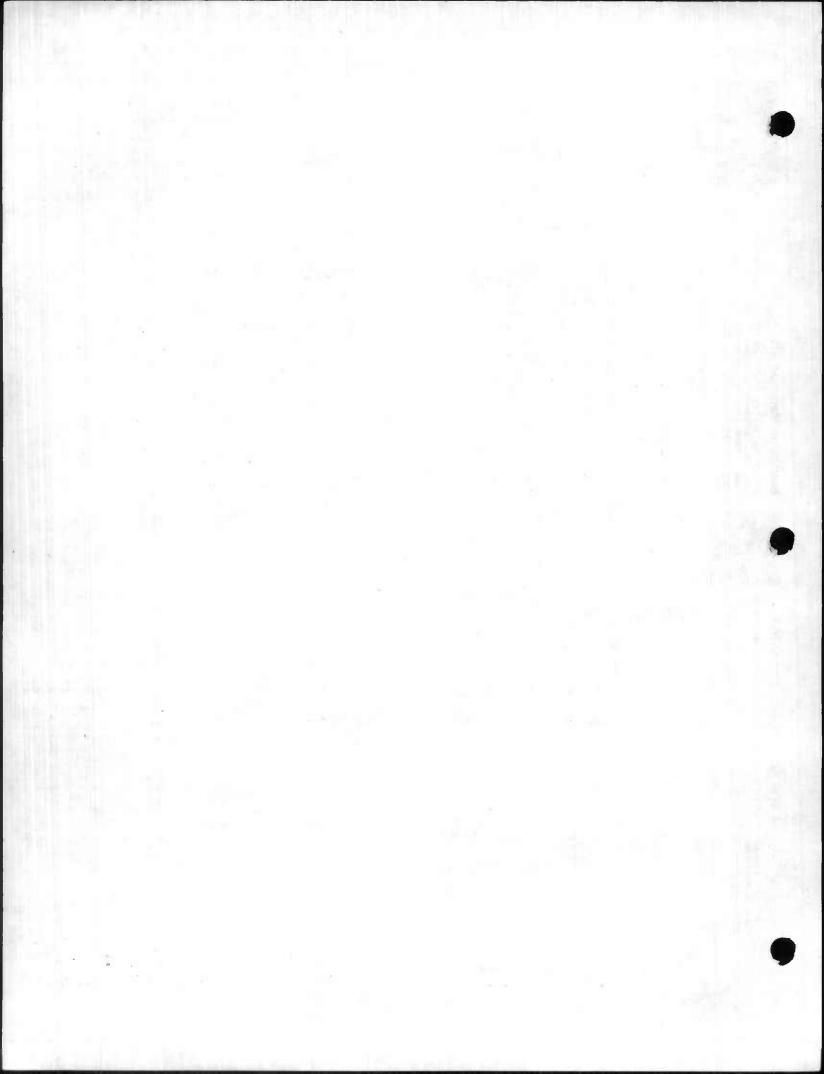
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** KUTH ANN 2:30AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIM If Under 24 Hrs. INIVERSITY DF MARY LAND 8. Date of Birth (Month, Day, Year) AUG. 23, 1 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 20 F Months Days Hours MARYLAND 216.54.9874 49 Yrs. 1949 Director Usuai Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show Charles Maryland Waldorf 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or munt be U.S.A. 12040 Pierce Road 20601 Funeral 12. Was Decedent Ever In U,S. Armed Forces?
1 ☐ Yes 2 ☑ No M Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Charles County Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Board of Education d 2 should be filed w th and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important; if Item 27 is merically in Jury or å George Edwin Collier, Sr. Anna Ruth Carroll 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert A. Hall/Husband 12040 Pierce Road, Waldorf, Maryland 20601 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Frinit#/Memorial Gardens01-22-1999 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses The Huntt Funeral Home, Inc. MO1095 DAVID A. GOFF P. O. Box 156, Waldorf, Maryland un Do not enter the mode of dying, such as cardiac or respiratory arrest, 20604 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final RENAL FAILURE disease or condition resulting in death) Examiner Examiner MONTRY HEMORRHAGE thet the death certificate be executed and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760. Physician/Medicai Due to (or as a consequence of): USB Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 200 No 3 Probably 4 Unknown signed to Records, À 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 12 apatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

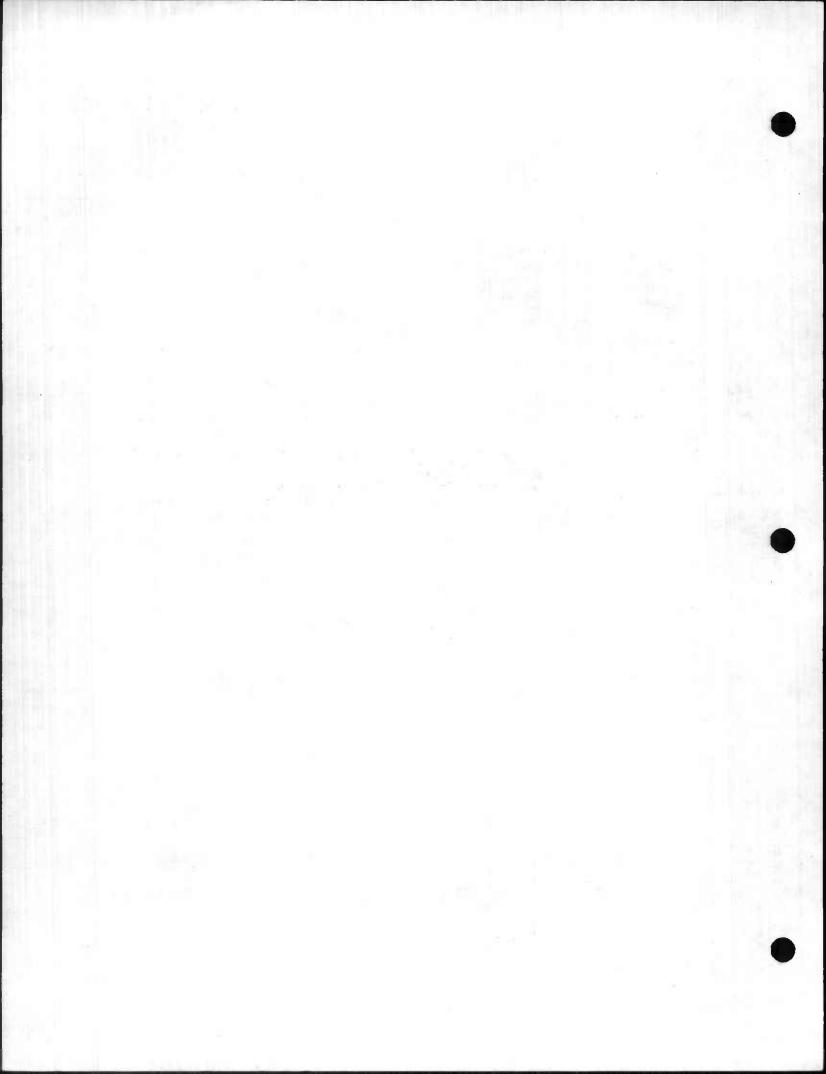
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARYLAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRACE L. CARNGAL, M.D. UNIVERSITY OF MD MEDICAL SYSTEM 222 SO. GREENE ST. BALT., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 Registrar



State of Maryland / Department of Health and Mental Hygiene 99 02571

	Certificate of Death Reg. No.													
Physician	1. Decedent's Name (First, Midd									2. Dete of De Month		Year	3. Time of Deetl	
Physician /Medical	EVELYN KERN	HUDS0	N							January	20,	1999	11:48 A	
Examiner	4s Facility Name (If not institution			4			ocation of Deatl		unty of Death					
	5 Mooncoin Cir	-				***			dort			rles		
Funeral	5. Social Security Number	6. Sex 1 ☐ M	2/VF	7. Age (In yrs 86	s. last birthday) Yrs.	Months Months	Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)	9. Birth	place (State or Fore	
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and a	Maryland Char	205			Indian	. Hoa	hd					1 ☐ Yes 2 ☐		
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ral', or items 23a or 28a-f show Examiner must be notified at	11. Merital Stetus 12. Was Decedent Ever in U.S. 13								nin? (Sn	ecity Yes or No		Rece - Amen	ican Indian.	
Pur Pur	1 Never Married 2 Me.	rried 1	med Fo	orces?	1.0.	f Yes, sp	ecity Cube	en, Mexican	Puerto	ecify Yes or No Rican, etc.)		Bleck, White	, etc.	
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To B	Ralph A. Kern							Bess	ie E	E. Tippe	ett			
SEE	19a. Informent's Neme/Ralation	ship (Type, P	Print)							ral Route Numb				
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14	20a. Method of Disposition		,	POCH I	Place of Dispo	sition (Ne	me of	no)	1	Date	20c. Locati	on - City or T	Town, State	
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	David A. G				C D	. 0.	Box	156,	Wal	dorf, M	2060	4		
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been signed by the atte should be detached for letted by Physicia									14	24a Was	en autopsy	24b V	Vere autopsy tinding	
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ther tunera	27. Manner of Death 1. ■ Netural 5 □ Pendi	ng 28	Ba. Date (Mon	of Injury th, Day Year)	28b. Tima of Injury		28c. tnjur Wor			28d. Describe	how injury oc	curred		
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To the Funeral D completely filled is Medical Cel	(Check only 2 Medical	ng Physician Examiner: (n: To the	best of my kn	owledge, death	occurre	at the tin	ne, data an	d place,	and due to tha	causa(s) end	manner as	stated.	
To the Funeral Director: Affer thi completely filled in by the funeral Medical Certification: 1	ane)	A 10	and man	ner stated.						ure time,	Jaro erro ple	, who due	uro oauso(s)	
To the	29b. Signeture and title of certific	11/	10			29	c. Licens	e number			29d. Date si	gned (Month	Day, Year)	
		1//	10	un			02	25	14		- /	1211	79	
	30. Name and address of person	Who comple	ted caus	se of death (Ite	m 23a) (Type, I	Print)			-			+ *		
	Dr. Timothy R.						202,	Waldo	orf,	MD 206	02			
State	31. Date filed (Month, Day, Year	1	32. R	legistrar's Sign	nature /		,							
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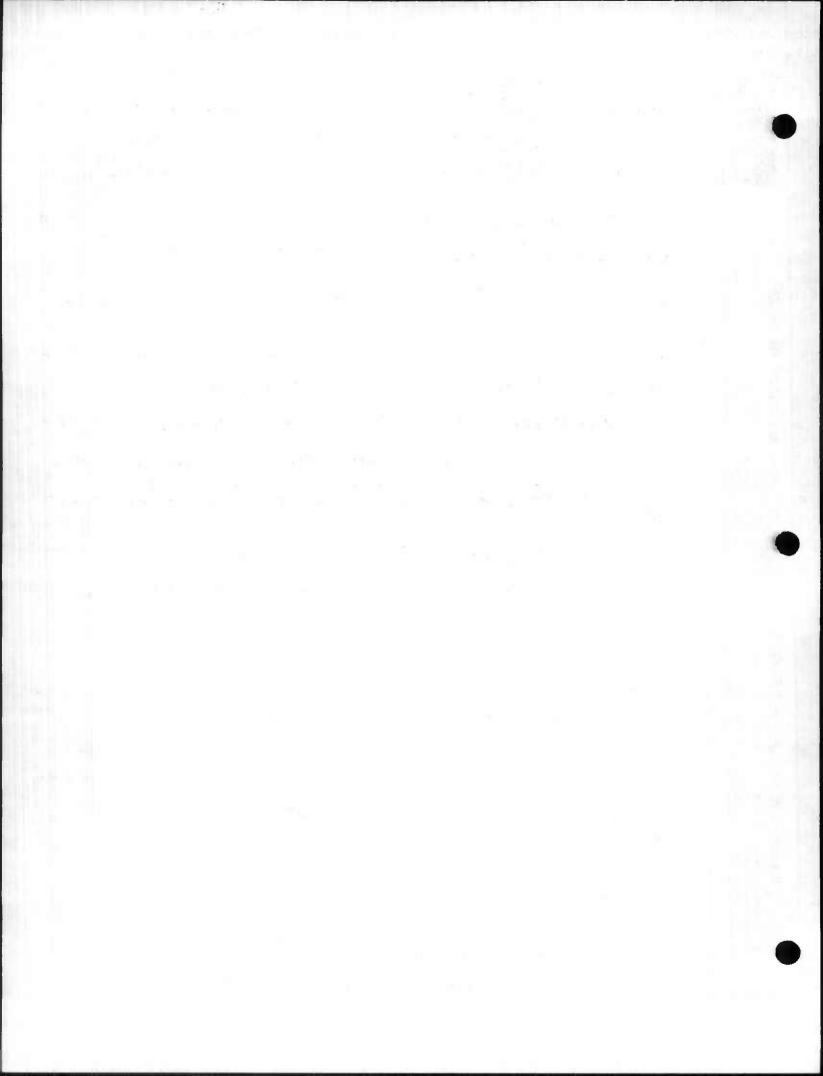


State of Maryland / Department of Health and Mental Hygiene (

					Ce	rtificate of	f Death	F	Reg. No.	UZ	216	
	Dharalai		1. Decedent'e Nema (First, Middle, Last)	4.4	E AT			2. Dete of Dee		Yeer	3. Time of Deeth	
	Physici /Medi		Mary Lee	- HAII				JANUAR		999	7:50 A	
į.	Examir		4a. Facility Nama (If not institution, giva	street end number)			4b. City, Town, or L	4.	-			
7			St Agnes Nursing	+ Rehab.	Center		5 llicott	City	How	GVA		
r	Funeral		5. Social Security Number 6. Sex	7. Aga	(In yrs. lest birthdey)	If Under 1 Yee		8. Date of Birth	h Vana)	9. Birthple	ce (Stete or Foraign	
	Director		216-36-6439	M 227	4 Yrs.	Months Days	s Hours Min.	March 9		MAry	iland	
	P.		Usual Residence of Decedent									
	the Meryler 28a-f show		10e. Stete 10b. County		10c. City, Town or Lo					100	I. Inside City Limits	
	the Meryle 28a-f sho	cto	Maryland Anne Ar	undel	Jess	υρ	·				1 ☐ Yes 2 🗷 No	
	it 10 %	Dire	10e. Street end Number			10f. Zip Code			10g. Citizen of V		13	
	death with the Meryland ma 23a or 28a-f show	-ca	7810 CLARK TO	20 C-6			794		USF	ł		
5-0020	or its	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Dates:		Was Decedent of If Yas, specify Cu 1 ☐ Yes 2 ☐ No	Hispenic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - Amaricar ck, White, etc		
0	72 hours "natural",	ted	15. Decedent's Edu	cation	16e. Dece	dent's Usuei Occu	upetion		16b. Kind of Bu	siness/Indu	stry	
	hin 7	Completed	(Specify only highast grade Elementary/Secondary (0-12)	completed) College (1-4or 5+	(Give	kind of work done DO NOT use retir	e during most of work ed)	ring				
2121	d within giene. r than	E O	12	4 College (1-40) 54	Regi	stered	Nurse		St Agn	Es H.	espital	
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/lai	Aenta Aenta rked tic e	ToE	Unknown OT	terbein			UnKi	1041				
Maryland	2 sho and h is ma		19e. Informent's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Stree	et end Number or Rui	rel Route Numbe	r, City or Town,	Stete, Zip C	ode)	
-			Susan Ward (St	pDaughter	2039	Red R	iver RJ.	Elders	burg n	10 2	1784	
ore	of He		20e. Method of Disposition		20b. Piace of Dispo cemetery, cra	sition (Neme of metory or other pl	ece)	Dete	20c. Location -	City or Town	ı, Stete	
Ĕ	Page nent o int: If i		1 ☐ Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stete	CARROLI C	remation	Inc 1	19/99	Hampsi	eAd.	MD	
Baltimore	permit. Pages 1 end Department of Health Important: If item 27 any injury or other tr p0cs.		21. Signeture of Funeral Service License	90	02	2. Neme and Add	rass of Facility					
0	88 = 58		John K A	ly l		2 Washie		Westmi		י מע	21157	
			23a. Phot. Enter the diseese, or compliant ok, or heart failure. List only or	cetions that new ed th						A	pproximate	
-	Physician		smook, or near failure. List only or	ie cause on eech line						lr C	nterval Batween Onset end Death	
1	/Medicai		Immediate Ceuse (Final	Disto	ui mate	ol	1 6.	1		i	6 m-	
	Examiner		disease or condition resulting In deeth)	Pi	ue to (or es e conse	Juanca of	nu ar	aires		1		
		Der		Bella	Verall.	Post	Essen M	Her V	Grean	4		
	icete be executed physician end s the bunel-transit	Examiner	Immediate Ceuse (Final disease or condition resulting In deeth) Due to (or es e consequence of):									
o,	an el		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury							į		
68760,	ysici	edicai	thet initiated events resulting in deeth) Lest	Dı	ue to (or as e consec	uence of):						
	E 00	5								i		
Вох	that the death certificate be executed by the attending physician and detached for use as the buriel-tran	Physician/				·			-	-		
	the eth	Sici	Part II. Other significent conditions con	tributing to death but	not resulting in the y	nderlying ceuse g	jiven in Pert I.	23b. Did to	obacco use co	ntribute to ti	he cause of death?	
P.0		Phy	Chemie	alstra	live le	lluma	y Mises	1 1 Y	(ee 2□No	3 Proba	bly 4 🗆 Unknown	
	8 5 8	þ	anome	oronn		/	1 200000					
Records,	v requires been sign should be	Completed						24e. Wes e perfor	en eutopsy med?	eveile	e eutopsy findings eble prior to	
ec	aw 2 s	pie					_			of de	olation of causa ath?	
<u> </u>	The ste h page	5						1□ Y	es 2 No	101	Yes 2□ No	
Vital	ysician: The i s certificete he director, page	Be	25. Was case referred to medicel axeminer?				26. Piece of Deat	h (Check only or	ne)			
of V		2	1 Yes 2 No	ospitel: 1 🗆 Inpatient	2 ER/Outpetie	nt 3 DOA	ther: Nursing Ho	ome 5 Resid	ence 8 Oth	er (Specify)		
0	ding Ph. After thi funeral		27. Menner of Death	28e. Date of Injury (Month, Dey	(Year) 28b. Time o	f 28c. Inju	ury at ork?	28d. Describe h	ow injury occur	red		
Ö	Attending or death.	atic	1 Aaturel 5 Pending investigation	(111011111)	injury injury		☐Yes 2☐No					
Division	or Attendented of the offer death Olivector:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Piace of Injury	y - At home, farm, st	eet, fectory, office	•	28f. Location (S City or Tow		er or Rural F	loute Number,	
	tal or A rs efter al Direc								,,			
	tospi 4 hou uner	edical	29a. Certifier 1 Certifying Phys	ician: To the best of e	my knowledge, deat	occurred at the t	time, dete end plece,	end due to the c	ause(s) and ma	inner as stat	ad.	
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral		one)	and menner stete	d.							
	5 × 100	Σ	29b. Signature end title of certifier	, /	. / \	29c. Licar	nse number	2	29d. Date signe	d (Month, De	y, Year)	
			My aux	in pul	cu (xx)	10	08/8		1-13	2	7	
			30. Neme and eddress of person who co	mpleted ceuse of dea	th (Item 23a) (Type,	Print)	0878 - Free	touist.	11 1	alli	yust m	
			ALEJANDRO	ME	IA MI	401	inch	envi	VL4.	21	222	

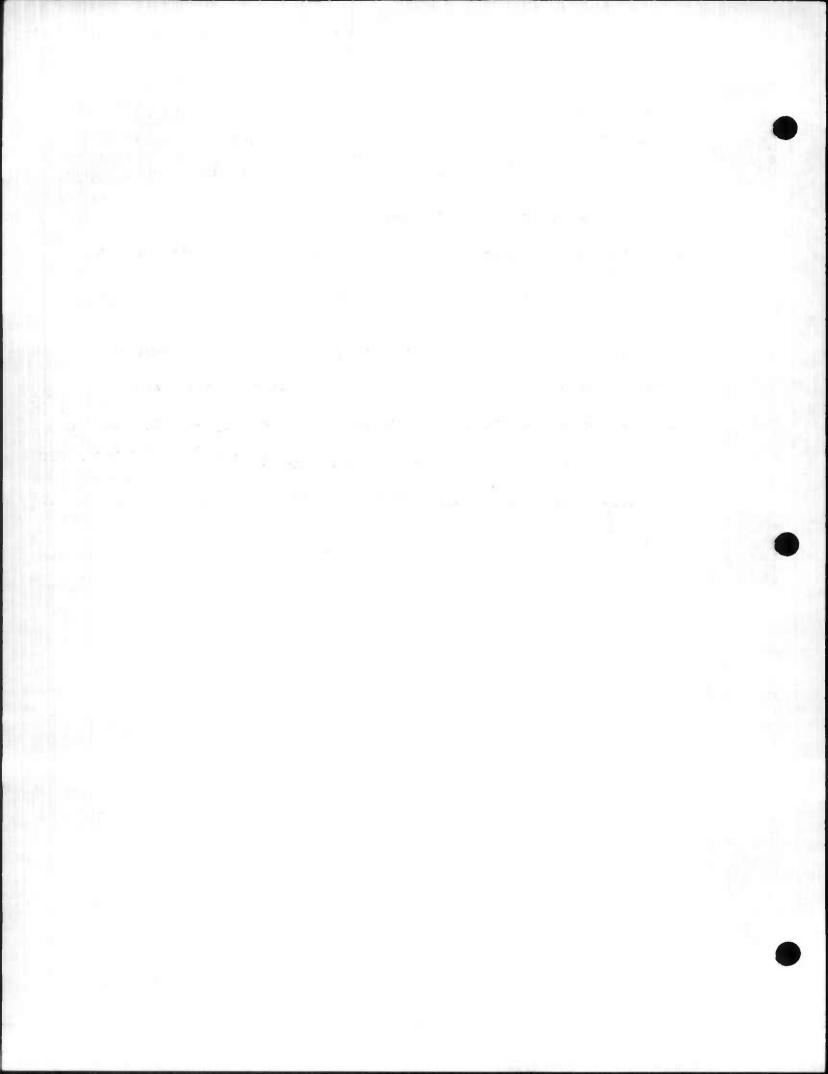
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1)

						rtificate o	Douth		leg. No.			
Physicia /Medic Examina		1. Decedent's Name (First, Midd						2. Date of Dea Month	Day	Year	3. Time of Dea	
		MARY ELLEN 4a. Facility Name (If not institution		mher)			4h City Town or	JAN Location of Death	4c. County	999	2:15PM	
		GOLDEN AGE G	21-21-21	1111			SYKESVI		CARE			
Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Ye	If Under 24 Hrs				lece (State or For	
Director		274-62-7256	1□M 2100 F	10	O Yrs.	Months Day	Hours Min	APR.19	Birth Pay, Year) 19,1898 September 1898 September 1			
2 A 11		Usual Residence of Decadent 10a. State 10b. County	/	10c. C	ity, Town or Lo	ocation				1	0d. Inside City Lir	
filed within 72 hours after death with the Maryland Hygiene. Hyber than "natural", or items 23s or 28s-f show ent, the Medical Examiner mant be notified a	to	MD BAL	TIMORE	10f. Zip Code							1 ☐ Yes 2 🙀	
	Director	10e. Street and Number						1	log. Citizen of V	What Coun	itry?	
	a	3406 BUTTONW	OOD COUR				36		UNITED	STA	ATES	
	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mai 3 ② Widowed 4 □ Divorced	If Yes Giv	rcas? 2[XNo /e		Was Decedent of If Yes, specify Co 1 ☐ Yes 2 ☒ N	f Hispanic Origin? (uban, Mexican, Pua o <i>Specify</i> :	Specify Yes or No- rto Rican, etc.)		e - Americ ck, White,	etc.	
"netural",	Completed by	15. Deceder (Specify only highs	nt's Education ast grade completed)	16a. Decedent's Usual Occup (Give kind of work done			supation ne during most of wo	orking	16b. Kind of Bu	ualness/Inc	dustry	
iene. 'than "natu	mpi	Elementery/Secondery (0-12)	College (1	-4or 5+)				ning most of working				
Hygie other t		17. Father's Name (First, Middle,	(ast)	HOMEMAKER			18. Mother's Name (First, Middle, I		DOMESTIC			
d da S	o Be	JOHN LEWIS							NE HOPKINS			
th and Mental Hygiene. 7 Is marked other than traumatic event, the Mental traumatic event e	To	19a. Informant'a Name/Relation:			19b. Mailii	ng Address (Stre	et and Number or F				Code) 2 1 1 2	
27 ls		FLORINE BALL	MAN/DAUG	HTER			NWOOD C					
of Heal fitem 2 r other		20a. Method of Disposition		20b.	Place of Dispo	osition (Name of metory or other p		Date	20c. Location -	City or To	wn, State	
nent int: i		13 Bunal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5					GARDENS	1/21/99	CINCI	NNAT	TI, OHIO	
Department Important: i any injury o		21. Signature of Funeral Sarvice	Licensee	1		2. Nama and Add		91 W	ILLIS	STRE	EET	
		MYERS FUNERAL HOME WESTMINSTER, MD 21									MD 211	
/Medical Examiner b bhysician and as the burial-transit	edical Examiner	disease or condition resulting in deeth)	a. 290	dues Cel	W (MICI							
g physician and as the burial-tran	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last	6	Due to	or as a consec	quenca of):	mentie				>1 year	
ttending physician and or use as the bunal-tran	edical	that initiated events	c	Due to	Jegerna også a consec	quenca of):	mentie				>1 year	
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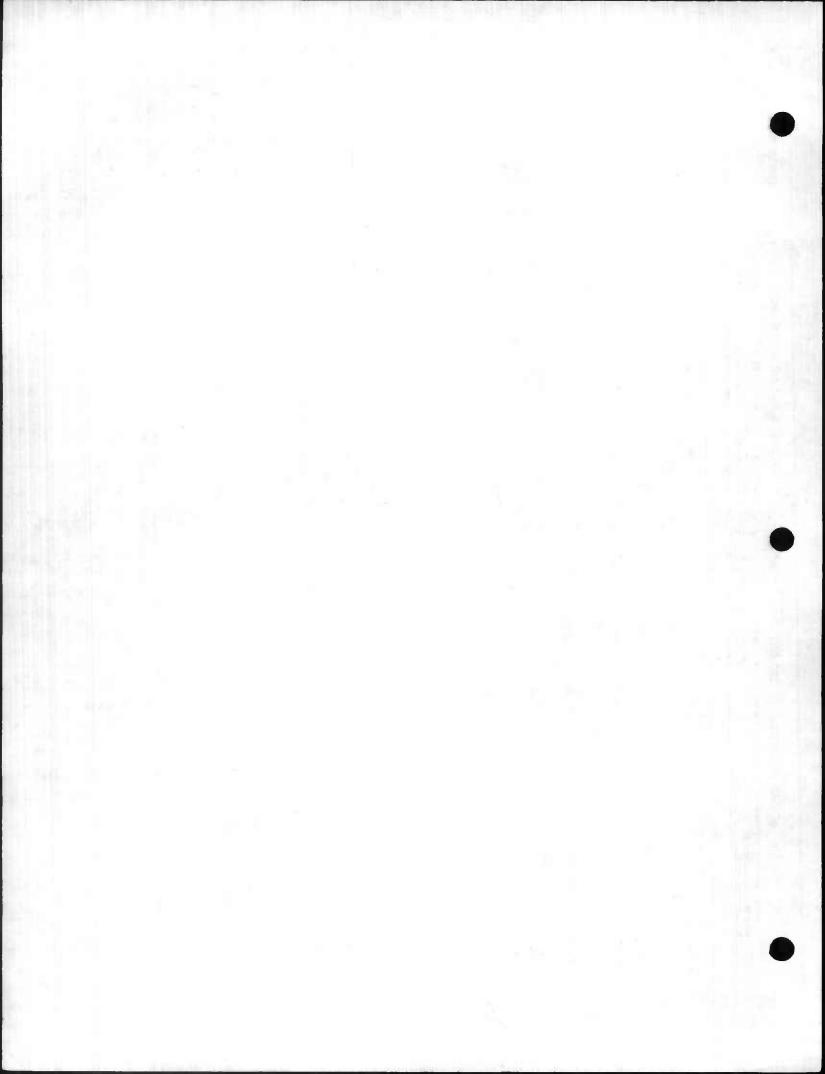


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** Alexandra Findlay Insley 20, 1999 6:40am January /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gaithersburg Montgomery Village Care & Rehab. Center Montgomery 7. Age (In yrs. last birthday) | If Under 1 Year | Months | Days If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 6 Sex Birthplace (State or Foreign Country) Funeral 1□M 2\ F Director April 27, 1932 364-34-2763 66 Michigan Usual Residence of Deceden the Meryland 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or hems 23a or 28a-1 show traumatic event, the Medical Examinar maint be political at 1∰Yes 2□No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 203 S. Washington Street United States Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 INo Specify: þ 3 ☐ Widowed 4 ☐ Divorced permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", any injury or other traumatic avera-White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 5+ Elementery School Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Findlay Helen Keyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Insley (Husband) 203 S. Washington Street, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1/20/99 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 le l L 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximata fnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final preumoria disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner semle dementio physician and the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by 3 Probably 4 Unknown 1 Yes 2 No p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen hes 1 Yes 2 ₹ No 1 ☐ Yas 2 1 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA To Other: 4 M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No this funaral To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Tes 2 No investigation 2 ☐ Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D33443 January 20, 1999 Goele. - mo 30. Name and address of person who complated cause of death (ftem 23a) (Type, Print) Rockville, and 20851 Rol Alan R. Pollack, m.D. 809 Viersmill 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks JAN 22 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Death JANUARY 21, 1999 7:35 A.M. H. JOHNSON, SR. 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth WILSON HEALTH CARE CENTER AT ASBURY VILLAGE **GAITHERSBURG** MONTGOMERY 7. Age (In yrs. lest birthdey) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 1∏ M 2□ F Deys 93 Aug 22, 1905 South Carolina Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of Whet Country? 20877 United States 333 Russell Avenue 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Bleck, White, etc. 1 XYes 2 No 1930-If Yes, Give Yeer or Dates: 1960 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specity: 3 ☐ Widowed 4 ☐ Divorced White 1960 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Colonel U.S. Army 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Holley Laura Luther Johnson 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) College Park, MD Bruce H. Johnson, Jr., 9402 Limestone Place, Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Jan 26, 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Number 2 Cremetion 3 Removel from State 4 Donaldon 5 Other (Specify) Mt. Olivet Cemetery 1999 Nashville, Tennessee 21. Signature of Funeral Service licenses 22. Name end Address of Fecility DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877 e, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, List only one cause on each line. Approximete Intervel Between Onset end Deeth asphation lwk proumonitis Due to (or es e consequence of): cerebras vascuear accident Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Hypertensian 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

physician end the buriel-transit

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funeral director,

Certification:

After this

after deatl a 24 hours after dea Ne Funeral Director pletely lilled in by th

To the Hosp within 24 hos To the Fune completely II

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The law requires that the death certificete be executed

Attending Physician:

6 Hospital

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiena. Important: If itsm 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

BRUCE

251-64-3672

Maryland

10e. Street and Number

Charles

10e. State

Directo

Funeral

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Completed

Be

Sequentially ilst conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet Initiated events resulting in deeth) Lest

Immediate Ceuse (Finel

diseese or condition resulting in deeth)

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Physician/Medical Examiner Attalians Denentia. à Completed 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number

Medicai 29b. Signeture end title of certifier

041794

January 21, 1999

uscella ('allahan tyenno 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

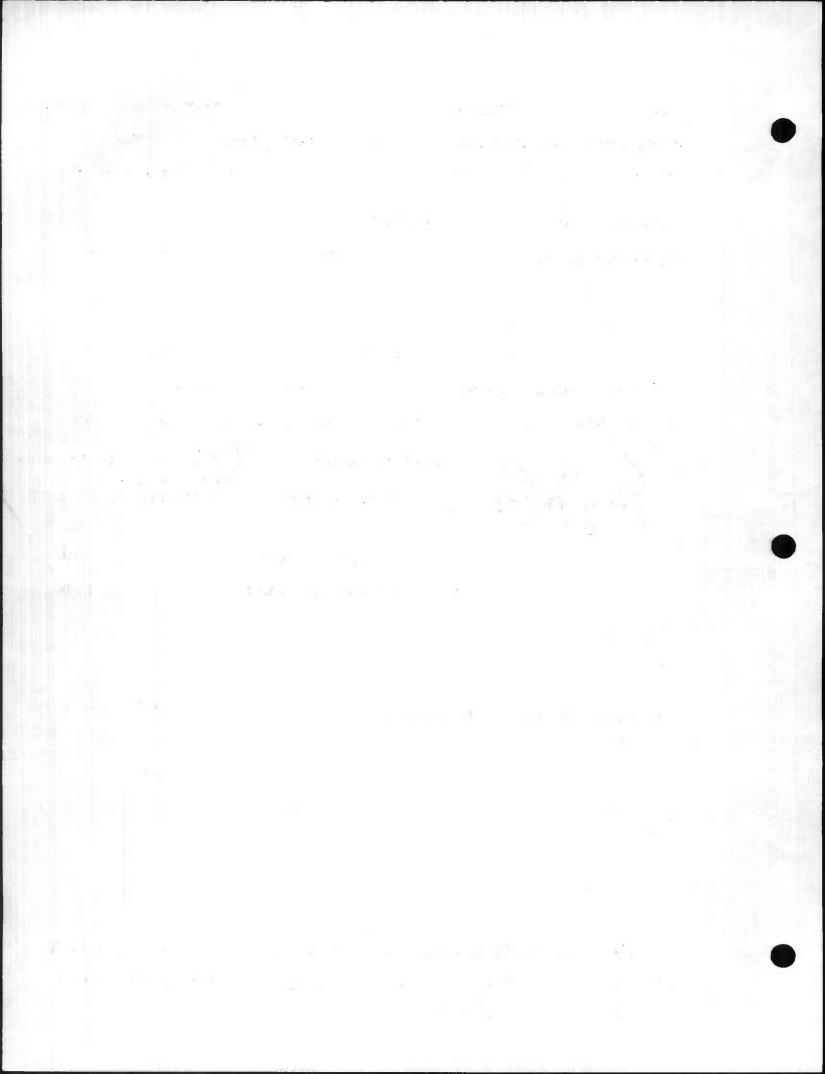
1999

Lyonmo P. Callahan -31. Date filed (Month, Day, Year) JAN 22 32. Registrer's Signeture

911 Russell

Are GalHersburg, MD 20879

State Registrar



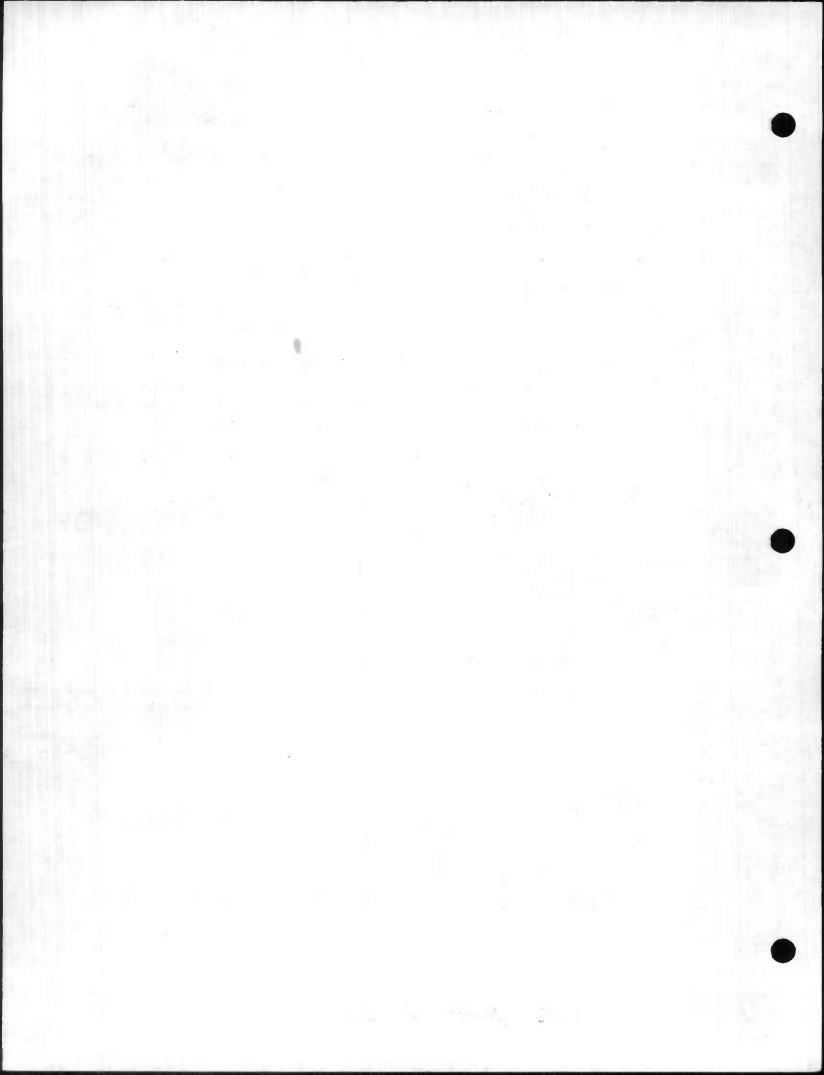
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** Walter Louis Jubien January 13, 1999 3:35 PM /Medical 4b. City. Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 24 Hrs. If Under 1 Yeer 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1⊠M 2□F Director 119-14-2492 Feb. 18, 1926 New York Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1□Yes 210 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 931 Wild Forest Drive 20879 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ≦ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1944/1946 1 ☐ Yes 2 ☐ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens Important: if Item 27 Is marked other than "n any Injury or other traumatic avant Elementery/Secondary (0-12) College (1-4or 5+) Self Employed Interior Design 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Walter Edwin Jubien Helen Guilfoil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 931 Wild Forest Dr., Gaithersburg, MD. 20879 Maxene E. Jubien/Wife 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete t⊠Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/19/99 Quantico, Virginia Quantico National Cem. 21. Signeture of Funerel Service License 22. Neme end Address of Fecility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oriset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Heart failure Few days Congestive Examiner Examiner physician and s the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. obstructive Pulmonary 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peeu Disease 1 □ Yes 2 □ No certificate Division of Vitai To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Dete of tnjury (Month, Day Year) 27. Menner of Death 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 46398 Granta Jan 14th, 1999 12+ 121 congressional lane Rockville, MD 2 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) # 409 G-Gupta, mo Ghanshyam aup to 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar **DHMH 16 Rev 6/95**

JAN 1 9 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death

Month

/Medicai Examiner **Funeral** Director 6 Негля 23а ò OWEN

traumatic event, the Medical Examiner must be notified at "natural". d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "ne 1 and 2 should be Health and Mental Important: If item 27 is any injury or other tran ō Department

Physician /Medical Examine

physician and the burial-transit attending p ed by the a signed by t d be detach been sig page 2 Hospital or Attending Physician: 24 hours aftar death. Funeral Director: After this certifica Nety filled in by the funeral director, i

P.O. Box 68760

Records,

Division of Vital

Physician WILLIAM OWEN JONES JANUARY 19,1999 5:49 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death MEDICAL CENTER LAPLATA CHARLES CIVISTA If Under 1 Yaer If Under 24 Hrs.
Months Days Hours Min. 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplaca (Stata or Foreign Country) Months Days Hours 1☐M 2□F 479-24-4652 Yrs. 71 June 24 1927 Illinois Usual Residence of Decadent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director Maryland Charles Waldorf 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 3093 Eutaw Forest Drive 20603 Funeral USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Race - Amarican Indian, Bleck, Whita, atc. 1 XYes 2 No If Yas, Give Yaar or Datas: 1 ☐ Navar Merried 2 X Married 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 Widowed 4 Divorced Completed Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast greda completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elamentary/Secondary (0-12) Deputy Assistant Inspector General US Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meldan Sumama) Be 2 Ralph A. Jones Nadine Dulcie Shouse 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Routa Number, City or Town, Stete, Zip Code) Jill M. Jones (Wife) 3093 Eutaw Forest Drive Waldorf, MD 20603 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriale 2 X Crametion 3 ☐ Ramoval from Stata on 5 Othar (Specify) 4 Dona Metropolitan Crematory 1-20-99 Alexandria, VA 21. Signature 22. Nama end Addrass of Facility M00173 J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695 23u. Part. Effect the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, whick, or heart failure. List only one ceuse on each line. Approximata Intarval Between Onsat end Death Immediata Causa (Finai disaase or condition rasulting In death) Examiner Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Diseesa or injury that initiated evants rasulting in death) Last Due to (or as a cons-Physician/Medical Due to (or a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Wera autopsy findings availabla prior to completion of cause of deeth? 24a. Was an eutopsy performad? 2 No 1 ☐ Yas 2 ☐ No Be 25. Wes cesa rafarrad to medicei 26. Piace of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yes 2 No 1 Opatiant 2 ER/Outpatient 3 DOA Certification: To 27. Mannar of Death 28b. Tima of 28a. Deta of Injury (Month, Dev Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be determined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stata) 4 Homicida Certifying Physician: To the best of my knowladge, deeth occurred et tha time, dete and plece, and due to the ceuse(s) and mannar as stated.

Con the basis of exeminetion and/or investigation, in my opinion, deeth occurred at tha tima, data end piece, and due to the cause(s) edicai 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-20629 30. Nama and address of person who completed ceusa of death (Item 23a) (Type, Print WATHEN M.D. 11345 PEMBROOKE SQUARE SUITE 103 WALDORF MD. 20603 GEORGE H.

DHMH 16 Rev 6/95

State

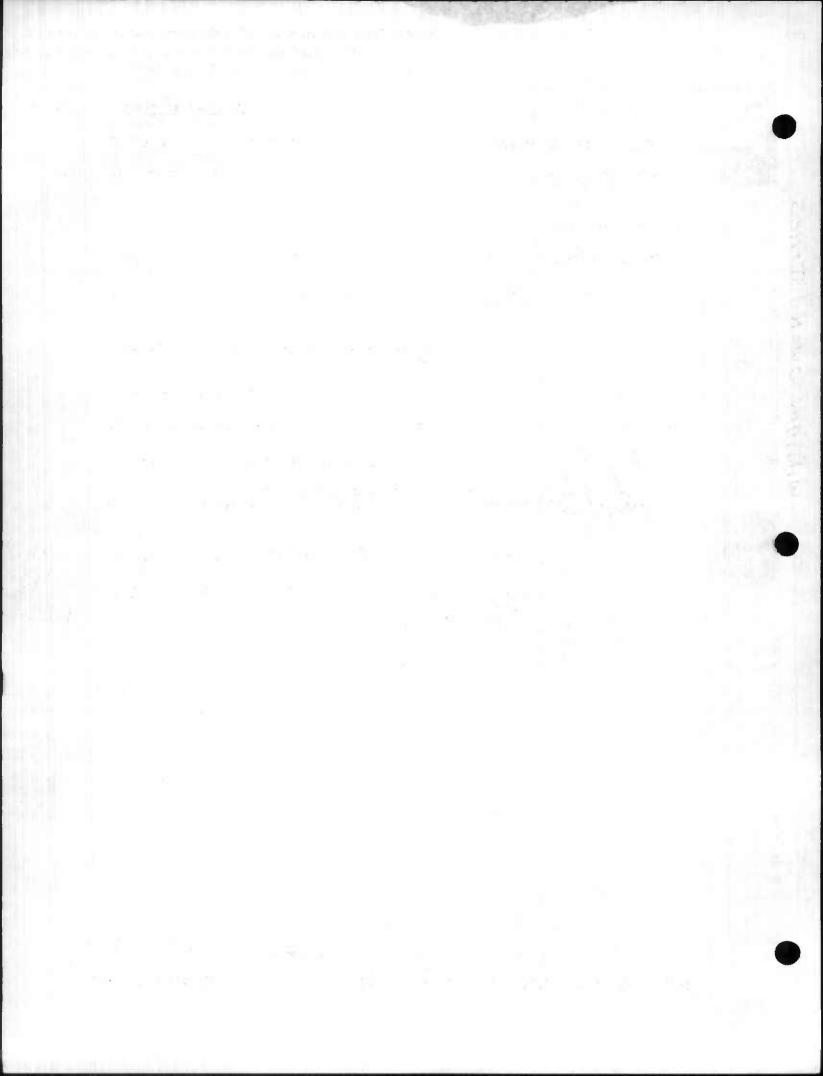
Registrar

31. Data filed (Month, Day, Yaar)

JAN 22

32. Ragistrar's Signature

within 24 hours a To the Funeral D completely filled i

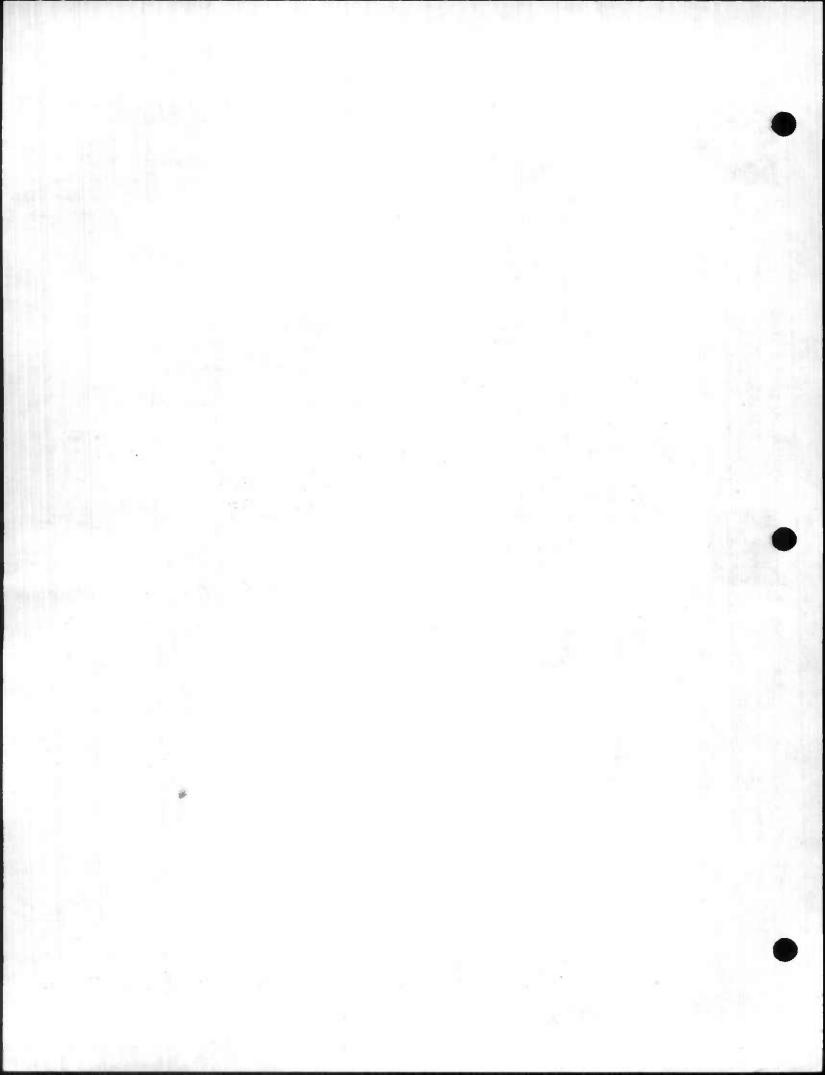


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant'a Nama (First, Middle, Last) 2. Data of Death beorbe ouver TAELEK **Physician** 155 M /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll County General Hospital Westminster If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Sep 21, 1918 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 15 M 2□ F Months 217-09-7435 80 Maryland Director Usual Rasidence of Decedent 10a Stata 10b. County 10d. Inside City Limits 10c. City. Town or Location Marriottsville 1 Yes 2 No Director MD Carroll 289-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 21104 U.S.A. 1720 Arrington Road "natural", or hams 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ŽXas 2 □ No If Yas, Giva Yaar or Datas: WW. 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White À WWII 3℃ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Wood Working Carpenter 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be h and Montal ? T is marked of 8 Grace Edna Zepp George Frederick August Jaeger, Jr. Pages 1 and 2 should 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1732 Arrington Road Marriottsville, MD 21104 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If Item 27 is any injury or other tra Mr. David L. Jaeger (son) 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Burial 2 Cramation 3 Ramoval from Stata 1/21/99 Sykesville, MD Lake View Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Hee Duan Sykesville, MD 21784 (410) -795-1400 Sykesville, MD 21784 (410) -795-1400 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Due to (or as a consequence of):

Distance - Acute EtacenBarron

Due to (or as a consequence of): /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner physician and the bunal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last PNEUMONIA P.O. Box 68760, Physician/Medical Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yea 2 No Division of Vital Be 25. Was casa ralarred to medical axaminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? he Hospital or Attending P in 24 hours after death. he Funeral Director: After ti pletely filled in by the funera After 1 Natural 2 Accident 5 Panding 1 Yas 2 No invastigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At homa, larm, street, factory, office building, atc. (Specify) 4 ☐ Homicida 29a. Cartifiar Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. within 2 29c. License number 29d Date signed (Month, Day, Year) 221 cenvary a of death (Hern 23a) (Type, Print) 200 memorial the, Westminster, md Cener SCHNer BERDER, MO CAMOUL COUNTY 31. Data liled (Month, Day, Year) 32. Degistrar's Signatura State JAN 1 9 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 02579 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Dass 1750 sachelle 99 phoson JAN 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Westminster, Konsland Gen 6. Sex 7. Age (Irkyrs. last birthday) Carroll ion 0 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Months Days Hours 1□ M 2⊠ F 414-12-1386 Aug. 24, 1918 Tennesee 80 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 √ Yes 2 No CARROLL WESTMINSTER 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 UNITED STATES 15 RIDGE VIEW DRIVE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [X]No If Yas, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11 Marital Status Bleck, Whita, etc. 1 Never Merried 2 Merried 1□ Yas 2Ĭ No Specify: Specify: WHITE 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing agent Chemical 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) AUBREY B. BASS ELLA PAYNE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) REBECCA PEARSON/DAUGHTER 15 RIDGE VIEW DRIVE, WESTMINSTER MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☑ Removal from State MOUNT OLIVET CEM. 1/21/99 NASHVILLE, TENN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Survice License 22. Name and Addrass of Facility WILLIS STREET MYERS FUNERAL HOME WESTMINSTER, MD 21157 23a. Hart L Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, mock, or have failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediata Cause (Final disease or condition resulting in death) Intertinal Iselenio Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heavet Disense 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? abstructive Offro purulin and 25. Was case refarred to medical examiner? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Physician

/Medical

Examiner

10e State

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Funeral

Director

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Norms 23a deeth

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permit. Pages 1 and 2 should be filed within 72 l Department of Heelth and Mental Hyglene. Important: if Item 27 is marked other than "natu any Injury or other treumatic event, tra Mental page.

Director

Funeral

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Completed

Be

the Maryland

72 hours efter

Baitimore, Maryland 21215-0020

Examiner ettending physician and for use as the burlei-transit Physician/Medical þ Completed To the Hospital or Attending Physicien: within 24 hours etter deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 2 Certification:

à

this certificate

Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

1 Tyes 2 18 No 27. Manner of Death

1 Naturat

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify)

Hospital: 1 ☑ Hopatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

5 Pending invastigation

6 ☐ Could not be

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JAN/17(9)

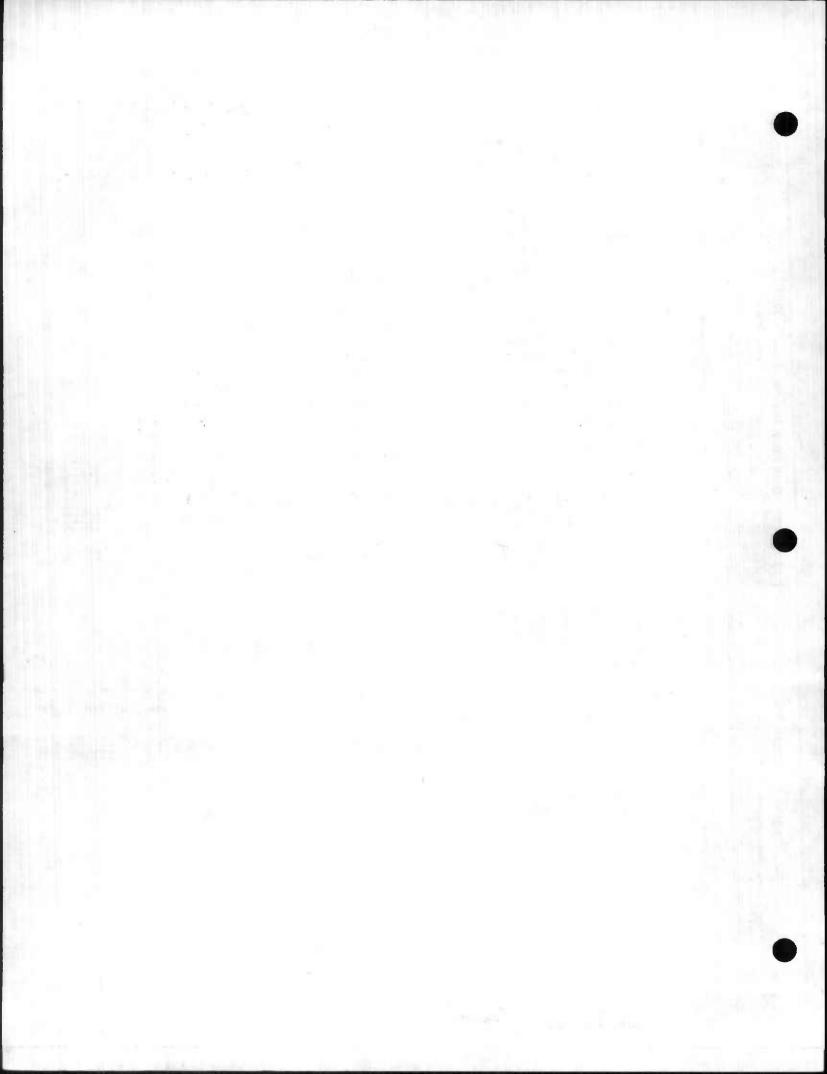
30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 295 Stoner Ave we COKEL Westminster DONAM Maryland 21157 31. Data filed (Month, Day, Year)

State Registrar

edical

JAN 20 1999

32. Registrar'a Signatura Sparks



State of Maryland / Department of Health and Mental Hygiene 99 02580

LESLIE JEN	KINS State of Maryland / Department of Health a		Reg. No.	02580		
Physiciar	1. Decedent's Nama (First, Middle, Last)	2. Date of Dec Month JAN	Dev Yaar	3. Time of Death 1656 PM		
/Medica	LESLIE WAYNE JENKINS	Wn, or Location of Death	-			
Examine	DIMITAIGUE A DEGENARA ELOGO	SBURY	WICOMIC			
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	24 Hrs. 8. Data of Birt Min. (Month, Da	th 9. Bir	thplaca (State or Foreign		
Director	212-56-1331 191 48 Yrs.			ryland		
hend is	Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits		
Man	Maryland Wicomico Salisbury			1 ☐ Yes No		
vith the Me	10e. Street and Number 10f. Zip Code		10g. Citizen of Whet Co	ountry?		
23a	5601 Mt. Hermon Church Rd 21804		USA			
72 hours effer death with the Maryland natural", or flems 23a or 284-1 ahow		n, Puerto Rican, etc.)	14. Race - Ame Black, Whit Specify:			
ed within 72 hours eff yglene. wr then "netural", or ft, the Weden Error		t of working	16b. Kind of Business	/Industry		
d within jene.	Elementary/Secondary (0-12) College (1-4or 5+) Mechanic		Automotive			
be filed of other work, to		er's Nama (First, Middle,	Maiden Sumame)			
should be ind Mental marked o	Arthur Littleton Jenkins Ethe	el Virginia				
- N	19a. Informant's Name/Relationship (Type, Print) Linda K. Peters Jenkins/wife 19b. Mailing Address (Street and Number 5601 Mt. Hermon Ch		- 11.			
b = 9 - 3	20a Method of Disposition 20b. Place of Disposition (Name of	Data	20c. Location - City or			
	1 XBurial 2 Cremation 3 Removal from Stata Cemetery, crematory or other plece) Springhill Memory Cardens	1/18/99	Hebron,	MD		
pemit. Page Department of Important: if any injury or	21. Sanuture of Pulleral Service Licenson 22. Nama and Address of Facilit	ly				
o de la companya	Holloway Funera 501 Snow Hill R 234 Part. Enter the disease, or complications that caused the dumb. Do not enter the mode of dying, such as pock, or heart feilure. List only one cause on each line.	II Home Proi	essional A	ssociation		
Examiner the second of the sec	Immediate Causa (Final disease or condition resulting in death) a. Contact gunshet woun Due to (or es à consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of):					
ding						
the death by the attention of the attent	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 23b. Did	iobacco usa contributi	a to the cause of death?		
£ × 70		10	Yaa 2⊠No 3□P	Probably 4 Unknow		
been should		perlo	ermed?	Wara autopsy findings available prior to completion of cause of death?		
			Yes 2 No	1 ZYes 2□ No		
releien: The secreticate director, pa		of Death (Check only o	nne)			
- K - 5	MOXYas 2□ No Hospitel: 1□ Inpatient 2▼ ER/Outpatient 3□ DOA Other: 4□ Nu	ursing Homa 5 Rasid		ecify)		
tal or Attanding P is shartdasth. I Director: After led in by the funer. Certification:	27. Manner of Death 1 □ Natural 5 □ Pending (Month, Day Year) 1 □ Natural investigation (Month, Day Year) 2 □ Accident investigation (Month, Day Year) 1 □ Yes 2 □		how injury occurred	. ^		
l or Attending ster death. Director: Atte d in by the fune	2 Accident Investigation 1-13-99 Unitariow 1 1 Yes 229 3 Suicide 6 Could not be determined education of the determined 1 28e. Place of Injury. At home, farm, street, factory, office	28f. Location (t Shot So Street and Number or R	C T		
o din Die	4 Homicide building, etc. (Specify)	Wicom!	wn, State) 560 / 1	Manyland		
To the Hospital or Attending Philipin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Madical Certification:		nd place, and due to the	cause(s) and manner a			
To th To th comp	29b. Signature and title of certifier 29c. License number		29d. Data signed (Mon			
	Stist & Mading NO O.C.M.E		JAN. 14	, 1999		
1211	30. Name and address of person who completed causa of death (Hem 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Bal	timore, Mar	yland 2120	1		
State Registrar	31. Data filed (Month, Day, Year) JAN 1 9 1999 32. Registrar's Signature					
negistiai	UNIT I USUS FOOKS					

Registrar DHMH 16 Rev 6/95

All I B 23 portion of reference

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #8, 1/20/99, BMW, Montg. Co. Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** 17, 1999 10:20PM JANUARY KROUTIL LUDWIG /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not Institution, give street end number) Examiner SILVER SPRING MONTGOMERY MANOR CARE NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 920 9. Birthplace (Stete or Foreign 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours Min 1 M 2 F MARCH 9, Yrs. 1999CZECHOSLOVAKIA 78 Director 579-07-4820 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiena. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examiner must be notified and 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo SILVER SPRING MARYLAND | MONTGOMERY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 20904 2501 MUSGROVE ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11. Meritai Stetus Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2K No Specify Specify: b 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) RADIOLOGIST MEDICAL 5+ 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNE VITOCH (UNK) JAROSLAV KROUTIL 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 21400 RIDGECREST DRIVE BROOKVILLE, MD 20833 LIONEL BOULIN/FRIEND 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 1/20/99 SILVER SPRING, MD 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 21. Signature of Funeral Service Linensee 22 Name and Address of Fecility HINES-RINALDI FUNERAL HOME, INC. ille N 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 Chur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one ceuse on eech line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final diseese or condition resulting In deeth) 10 YEARS PARKINSONS DISEASE Examiner Due to (or as a consequence of) Examine sician and burial-transit the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of). P.O. Box 68760, Physician/Medicai physi the t Due to (or es e consequence of) 80 USB ò signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes X No 3 Probably 4 Unknown that Records. by law requires 24b. Were autopsy findings available prior to completion of cause of death? should 24a. Wes an autopsy performed? Completed is certificate has director, page 2 1 TVas aN No 1 Yes 2 No Division of Vital Attending Physician: 26. Placa of Death (Check only one) Be 25. Wes case referred to medical examiner? Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: After 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after deat the Funeral Director of the Fu 6 Could not be determined 3 ☐ Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide ò Hospital 12 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only one)

26

State Registrar

31. Date flied (Month, Day, Year) JAN 20 1999

29b. Signature and title of certifier

PAUL ARMSTRONG, MD

14201 LAUREL PARK DRIVE SUITE 102 LAUREL, MD 20707 32. Registrar's Signeture

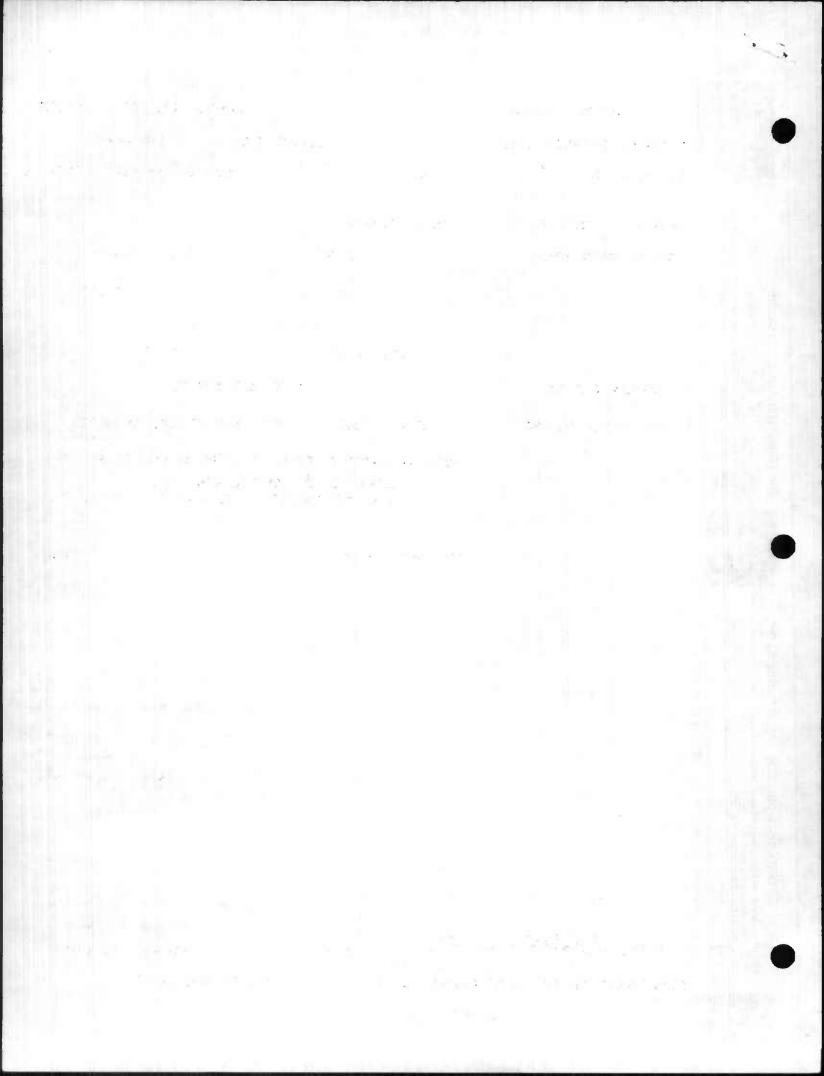
30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number

D43237

29d. Date signed (Month, Day, Year)

JANUARY 18, 1999

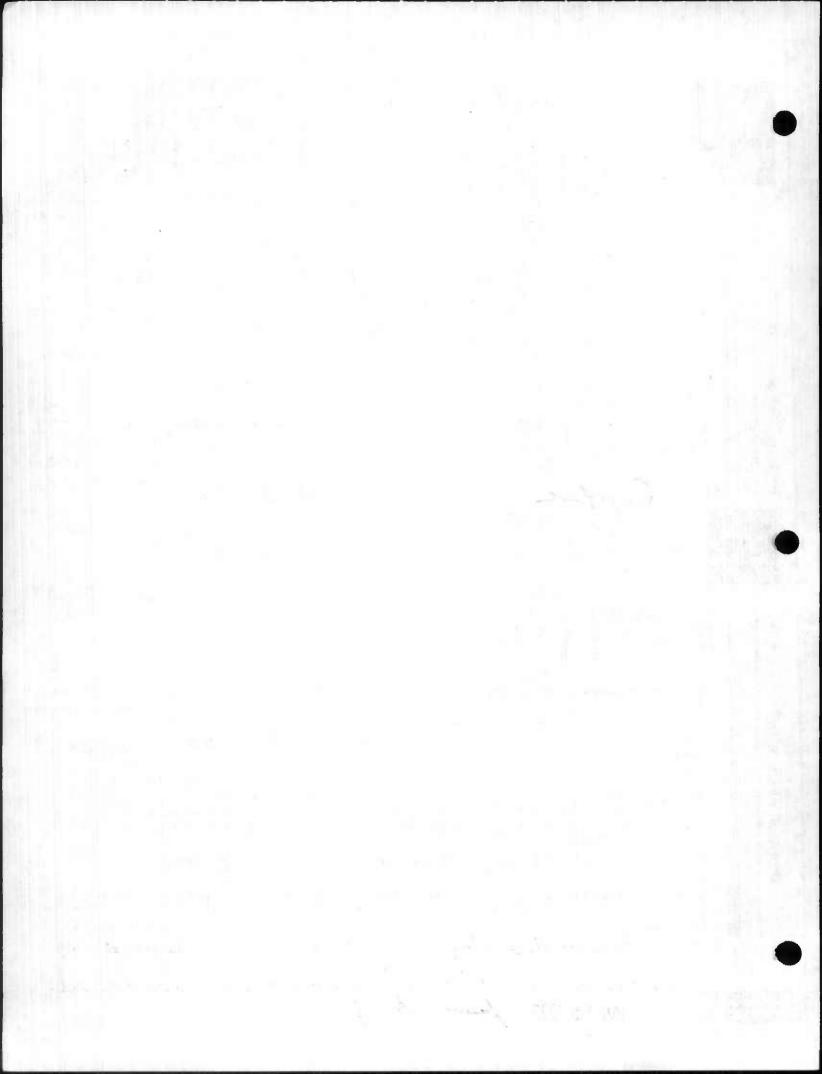


State of Maryland / Department of Health and Mental Hygiene

					Certificate d	of Death		Reg. No.	UL	006	
Physic	ian	Decedent's Name (First, Middle Day 1 C		1	SINE		2. Date of De Month	Dey	Year	3. Time of the	
/Medi			tephen Kul			Januar	ry 15, 1		2:30 PM		
Exami	ner	4a. Fecility Name (If not institution	A TOTAL CONTRACTOR	er)		4b. City, Town, or	Location of Deet	4c. County	of Death		
		Manor Care-Pot 5. Social Security Number		A (la la -4-)	hirthday) If Under 1 Ye	Potomac ear if Under 24 Hrs	1 2 2		omery		
Funeral Director		215-44-3787 Usual Residence of Decedent	6. Sex 1⊠ M 2□ F	Age (In yrs. lest)	Yrs. Months Da		(Month, De	y, Year)	9. Birthplac Country Washin	e (State or Foreign gton, DC	
aryland show	1	10a. State 10b. County		10c. City, To	own or Location	10d. Inside City Limi					
permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Maryland of Health and Mental Hygiene of the State of S	Director	Maryland Montg	omery	Ker	sington					1 ☐ Yes 2 Ñ No	
	금	10e. Street and Number			10f. Zip Cod			10g. Citizen of			
	- a	5025 Cushing Dr				20895		United			
ours after de rai', or item	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	W Van Ohn	s?	4 🗆 V 0 🖼 1	 Was Decedent of Hispenic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2⊠ No Specify: 			ce - American ck, White, etc Whit		
ithin 72 ho	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)			e. Decedent's Usual Oc (Give kind of work do life. DO NOT use ret	cupation ne during most of working ired)		16b. KInd of Business/Industry		try	
ygien ygien t. In	S		4	S	upervisor			U.S. Po		ervice	
of 2 should be filled within 72 hours af till end Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exam	To Be	17. Fether's Name (First, Middle, William Kullm					18. Mother's Name (First, Middle Zera Beech		le, Maiden Sumeme)		
s me		19a. Informant's Neme/Relations!	lp (Type, Print)	15	b. Meiling Address (Stre	eet end Number or R	ural Route Numb	er, City or Town,	Stete, Zip Co	ode)	
and and a salth		Patrick J. Kull	nan/Son	9	704 Huntmas	ter Rd., (Gaithers	burg, Ma	arylan	1 20882	
Demit. Peges 1 are Department of Hea mportant: If item 2 any injury or other ans.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc					, 1999	20c. Location	,	, State Maryland	
mit.		21. Signature Funeral Servica I		Joace	_22_Name end Add	dress of Facility		orivel o	brrng,	rialylan	
Depariment important in porce.		Kando for	1	м00198	300 West	dress of Facility Pumphrey Montgome e, Maryla	rv Avenu	. Home/R ie	ockvil.	le, Inc.	
7 34		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus		Rockvill not enter the mode of c	e, Maryla dying, such as cardia	nd 2085 c or respiretory a	0-2805 rrest.	Ac	proximate	
Physician /Medical		Immediate Cause (Final	only one cause on each	ine.					In	erval Between nset and Death	
Examiner		disease or condition resulting in death)	a. Pneum	nonia					Da	ays	
	ē				a consequence of):						
betu ansit	Examiner		b. Aspir	Aspiration Month							
icete be executed physician and s the burial-transit	Exa	Sequenfially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disesse or Injury that Initiated events	Domon	Due to (or as a consequenca of):							
sicia bui	edicai	Cause (Diseese or Injury that Initiated events	c. Deliteri	Dementia Due to (or as e consequence of):						onths	
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thet the death cert ed by the ettendin detached for use	Physician/	Part II. Other significant condition	s contributing to death	but not resulting	in the underlying cause	given in Part f.	23b. Did	tobacco uss co	ntributs to th	e causs of death?	
es that the	by Phy			10	Yss 2⊠ No	3 Probab	ly 4 Unknow				
2 S E	Completed t						24a. Was perfo	an autopsy med?	availa	autopsy findings ble prior to etion of cause th?	
	Co						10	res 2∭ No	1 □ Y	es 2 No	
ysician: The is certificate director, per	Be	25. Was case referred to medical examiner?				26. Place of Dec	ath (Check only o	ne)			
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fing find	Certification:	27. Manner of Death 1 XNatural 5 Pending investig.	ition	Time of injury M 1	ijury at Vork? ☐ Yes 2 ☐ No	28d. Describe I	now Injury occur	red			
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To the Hospital or within 24 hours effe to the Funeral Dir completely filled in	edical (29a. Certifier (Check only one) 1 ☐ Certifying 2 ☐ Medical E	Physician: To the best kaminer: On the basis and manner	of examination a	e, death occurred at the nd/or investigation, in my	time, date and placa y opinion, death occu	, and due to the	cause(s) and ma date and placa,	inner as state and due to the	d. e cause(s)	
Vithin Fo th	Me	29b. Signature and title of certifier	0 1 1.	29c. Lice	nse number		29d. Date signe	d (Month, Day	Year)		
20+1		Muchau	1 you	dy	D387	789		Januar	y 17,	1999	
		30. Name and address of person w		/							
		Michael J. Grad	M.D., 45	TU Mass	achusetts A	venue, N.	W., Wash	ington,	D.C.	20016	

DHMH 16 Rev 6/95

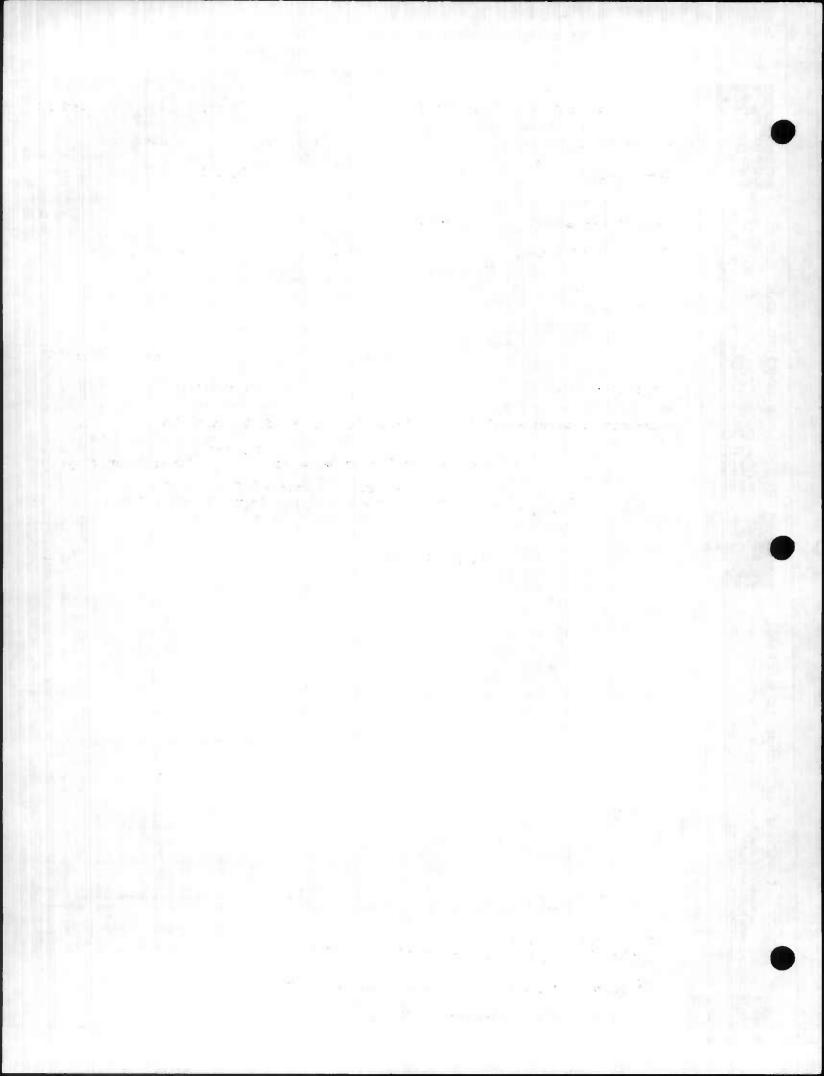
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State of Maryland / Department of Health and Mental Hygiene 9 9 2583

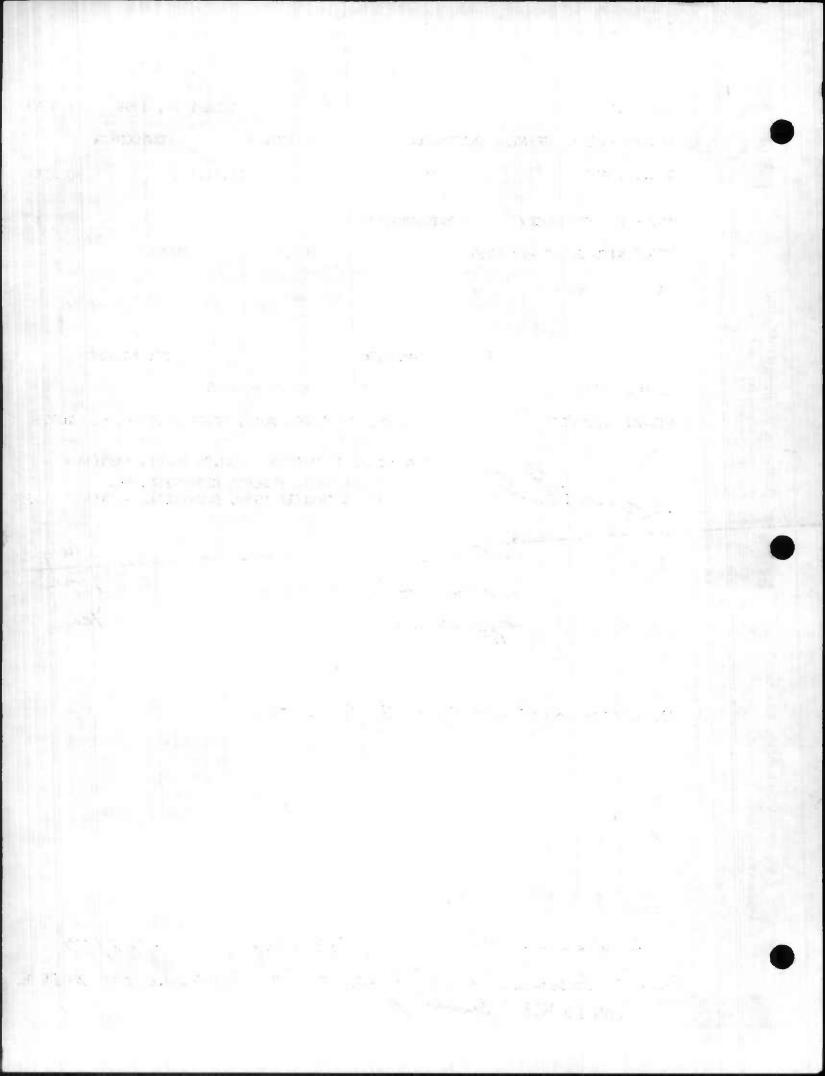
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	Examiner	4e Facility Neme (If not institution, g	ne (If not institution, give street and number)					4b. City, Town, o	or Location of Dee	th 4c. Cou	nty of Death		
		8703 Bells Mill	Road					Potomac			ntgome	ry	
	Funeral Director	5. Sociel Security Number 148–16–3401	Sex 1 M 2 □ F	7. Age (In yrs. 72	last birthdey, Yrs.	Months Months	Days	If Under 24 H Hours M		irth 09, Year) 0, 1920	9. Birth Cou New	intrv)	te or Foreign
7		Usual Residence of Decedent											
Mandar	28a-f ahow conflect at	Maryland Montgon	nery		omac	ocation							e City Limits
with the	r frams 23a or 28a-fa incrmust be notified Funeral Director	10e. Street and Number 8703 Bells Mill	Road 101. Zip 208						10g. Citizen of What Country? United States				
Maryland 21215-0020	if Health and Mental Hygiene. Itam 27 is merked other than "natural", or itame 23s or 25s-1 show other traumatic event, the Medical Examples must be notified as other traumatic event, the Medical Examples trained must be notified as other traumatic event, the Medical Examples to Itameral Director	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For	12. Wes Decedent Ever in U,S. Armed Forces? 1 ፟፟፟ Yes 2 □ No If Yes, Give Year or Dates: ₩W II		13. Was Decedent of Hispenic Origin? If Yes, specify Cuban, Mexican, Po			n? (Specify Yes or No- Puerto Ricen, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		i,
5-0	"natural", ndea	15. Decedent'a			16a. Dece	dent's Us	ual Occu	pation	varkina	16b. Kind o	f Business/Ir	ndustry	
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arylan should be	Ment mrka To								ila Ostr				
Aar	is m	19a. Informent's Name/Relationship							Rurel Route Num				
C	Health In 27 ther tr	Hannelore U. Ka	rpinski/W	Teat. 1	- (Di-				Potomac	-			
mor	int: if	20a. Method of Disposition 1 □ Buriel 2 □ Cremetion 3 4 □ Donation 5 ☒ Other (Spe	□Removal from S cify) Entombr	State	Plece of Disp cometery, cre te of I	metory or	other pla	usoleum	22, 1999	Silver	on - City or T Spring,		
Balt	Department important: if any injury o	21. Signature of Funeral Service Lic		/	RC RC	2. Name obert	nd Addr	ess of Fecility mphrey Fu	neral Home	/Rockvil	lle, In	c.	250_2805
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The same of	Medical xaminer	Immediate Ceuse (Final disease or condition Pancreatic Cancer								2 Months			
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K 68760,	J by the attending physician and etached for use as the bunat-transit Physician Amazachian Physician/Medical Examir	thet initieted events resulting in death) Last	Due to (or es e consequence of):										
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P.O.	signed by the attendir d be detached for use d by Physician/N		- 7						10	Yes 2][] N	lo 3 Pro	obably 4	f □ Unknowr
Records, P.O. Box 68760,	page 2 should b									s en eutopsy formed?	8	Vere eutop vellable prompletion of death?	
m =	page Con								10	Yes 2 N		☐ Yes	2□ No
of Vital	certificate rector, pag	25. Was cese referred to medicel examiner?	A CONTRACTOR OF THE CONTRACTOR						Death (Check only	one)			
Of V	this ce al dire	1 ☐ Yes 2 💢 No	Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
ion c	ath. r: After the se funera ation:	27. Manner of Death 1 X Naturel 5 Pending 2 Accident Investigat		f Injury h, Dey Year)	28b. Time of Injury	of M	28c. Inju Wo 1 [ny at ork?] Yes 2 □ No	28d. Describe how injury occurred				
Division at or Attending	within 24 hours eftar death. To the Funeral Diractor: After thi complately filled in by the funeral Medical Certification: 7	3 Sulcide 6 Could not 4 Homicide determine	nome, farm, st	o, farm, street, factory, office 28f. Location (Street end Number or Rural Rout City or Town, State)					ral Route N	vumber,			
Hospit	n 24 hour ne Funera plately fille edical	29a. Certifier 1\(\infty\) Certifying (Check only 2 Medical Ex	Physician: To the la aminar: On the ba end mann	sis of examina	owledge, deal ation end/or in	th occurre	d at the t	ime, dete end ple opinion, death o	ce, end due to the curred at the time	e causa(s) and e, date end ple	l menner as ce, end due	steted. to the cau	se(s)
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	30+1	Con MI	VI Sin		MUS		D1:	2890		Januar	y 19,	1999	
		30. Nemound address of person what M. Wisema					Ave	., N.W.	Washin	gton, I).C. 2	0015	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) **Physician** JANUARY 4:15 AM DAVID KATS 18, 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) **Funeral** t M 2□ F Yrs. 212.33.0490 84 RUSSIA 06.12.1914 Director Usual Rasidence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show r than "natural", or Nems 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MARYLAND MONTGOMERY GAITHERSBURG Direct 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 17060 KING JAMES WAY #505 20877 RUSSIA Funeral 72 hours after death 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. 1 Nevar Married 2 Merried 1 Yes 2 No If Yes, Giva Year or Dates: 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) filed within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANAGER TOY FACTORY of Heelth and Mental Hygintem 27 is marked other 18. Mother's Nama (First, Middle, Maidan Sumame) 17. Fathar's Name (First, Middla, Last) permit. Pages 1 and 2 should be Depertment of Heelth and Mental Important: If Nem 27 Is marked or any injury or other traumatic every SHIMMON KATS ETHEL SCHWARTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MIKHAIL KATS/SON 11504 PINEY LODGE ROAD, NORTH POTOMAC, MD 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) JUDEAN MEMORIAL GARDENS 1.20.99 OLNEY, MARYLAND 21. Signature of Funeral Service Lice EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Page: Enter the disease, or complications thet caused the death. Do not enter the mode of dylng, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final neumones disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the bunal-transit thet the death certificate be executed Saquentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events rasulting in deeth) Lest Dua to (or as a consequence of) Box 68760. Physician/Medicai Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobecco use contribute to the cause of death? Records, P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an eutopsy peen WB has The 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deeth funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation or Attending death. 1 Yes 2 No Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) aftar 4 Homicide 24 hours a Hospital edicai 29a. Certifier 🔀 Cortifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated. plataly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. To the I 29b. Signeture and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 3958 3 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Montrose Rd, Rockville MD 6/05 Teldman

State Registrar 31. Data filed (Month, Dey, Year) JAN 19

32 Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Dey Month Winifred L. Kilroy January 19, 1999 4:50 PM 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death

If Under 1 Yeer

Burtonsville

Montgomery

USA

Black, White, etc.

9. Birthplace (State or Foreign

Washington,

20905

Approximete Intervel Between Onset end Deeth

1 week

3 Probably 4 Unknown

24b. Were autopsy tindings available prior to

completion of cause of death?

1 ☐ Yes 2 ☐ No

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

Examiner

5. Social Security Number

Physician

/Medical

Funeral Director 28a-f show must be notified at

Director

Funeral

ğ

Completed

Be

"natural", or harra 23a or 72 hours after Hygiene. permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is mere-any injury or d 2 should be fi th and Mental F 7 is marked of

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

certificate be axecuted

Box 68760

Records, P.O.

Division of Vital or Attending Physician:

Hospital

physician and the bunal-transit 98 affending USB P 94 signed by t d be detach has certificate this hours after death.

Examiner Physician/Medical þ Completed Be Certification: To Director: After to d in by the funera the Funeral Director of the Fu edical To the Hosp within 24 hos To the Fune completely fi

If Under 24 Hrs. 8. Date of Birth (Month, Day, Year April 30, Days Months Year) 1 M 2 X F 90 577-01-1660 1908 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15316 Durant Street 20905 Wes Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien 1 ☐ Yes 2 🔯 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 St Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Steven A. Essex Ella Mae Hammon 19e. tntorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 15316 Durant Street, Silver Spring, MD Dennis E. Kilroy (son) 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Gate of Heaven Cemetery 1/22/99 Silver Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Feelilty Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21. Signeture of Funeral Service Ucens Silver Spring, MD 20901 latteres 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. immediate Cause (Final Myocardial Infarction disease or condition resulting in deeth) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequenca ot): Due to (or as a consequenca ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes ZZ No Parkinson's Disease 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Panding 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete)

Holy Cross Rehabilitation & Nursing Center

7. Age (In yrs. last birthdey)

Registrar

31. Date tiled (Month, Dey, Year) **JAN 21**

4 Homicide

(Check only one)

29e. Certifier

1999

and eddress of person who completed cause of death (Item 23a) (Type, Print)

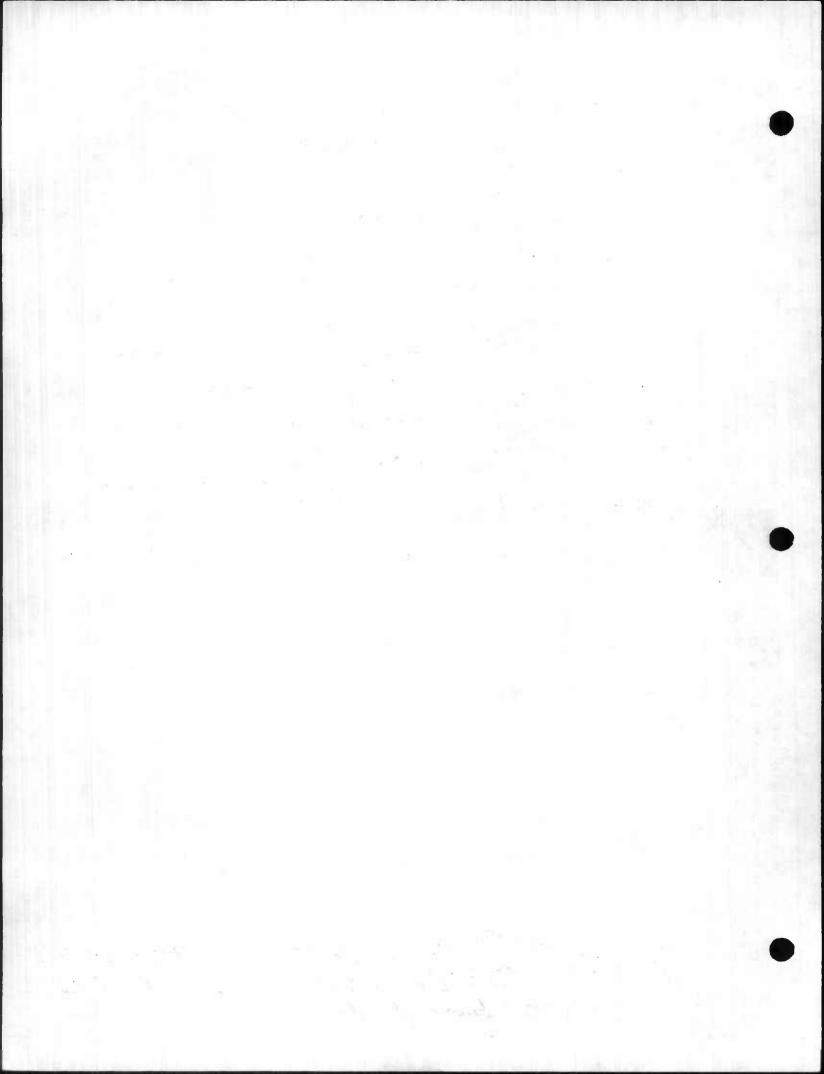
Res 32. Registrer's Signature

Dee

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

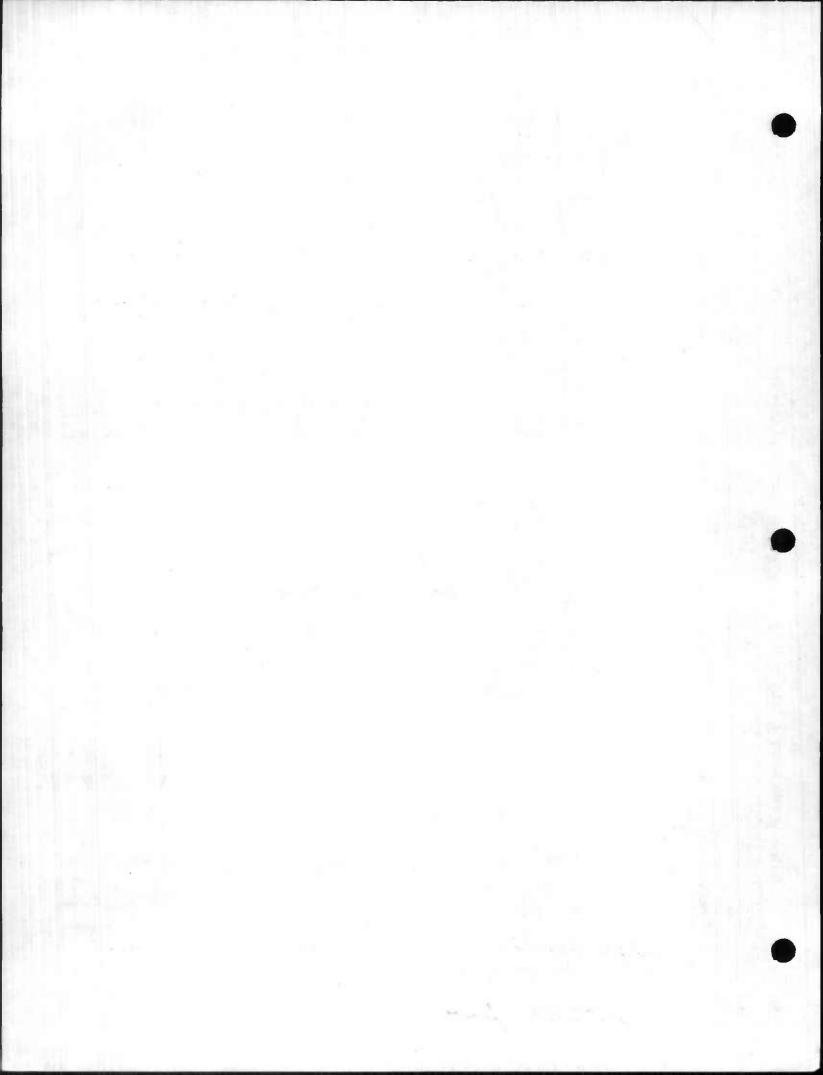
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number



State of Maryland / Department of Health and Mental Hygiene 9 9 12586

				Certifica	te of	Death		Reg. No.	02300	
Dhucisian	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	Dey	3. Time of Death	
Physician Medical	Ok S Kim						Jan 21	1999	02:10am	
Examiner	4e Facility Neme (If not institution, giv						r Location of Deatl			
	Holy Cross Hosp			Willade	er 1 Year	Silver S	-	Montg	*	
Funeral Director	5. Sociel Security Number 6. S 212-78-2909 Usuel Residence of Decedent	M 2X) F	(In yrs. lest birt	Months			n. (Month, Da	y, Year)), 1924	Birthplace (State or Foreign Country) Korea	
l show	10a. State 10b. County	10c. City, Town or Location						10d. Inside City Limits NXYes 2 □ No		
the M	Maryland Prince Georges College Park								Vhat Country?	
h with	6 4711 Berwyn House Road, #422 20740							United		
Maryland 21215-0020 2 should be filed within 72 hours efter death with the Maryland In and Mentel Hygiene. The marked other than "naturel", or items 23s or 28s-f show traumetic event, the Marical Emerican must be modified. To Be Completed by Funeral Director	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2000 If Yes, Give		13. Wes Dec			Specify Yes or No into Rican, etc.)	14. Race Blac Specify	e - American Indien, ck, White, etc. Korean	
Do Do Do		Year or Dates:	16a.	Decedent's Us	uel Occu	pation		16b. Kind of Bu	ISINESS/Industry	
Maryland 21215-0020 at a hould be filed within 72 hours et and Mentel Phygiene. The marked other then "naturel", or traumatic event, the Medical Event To Be Completed by F	(Specify only highest gra		+)	(Give kind of work do		lone during most of working		Home		
d 2 filled 2 filled 3	17. Father's Neme (First, Middle, Last,	0	ПОС	ISEWITE		18 Mother's No	eme (First, Middle,		ne)	
lan lid be ked of ic eve						Bok Kim				
T Mark	19e. Informent's Neme/Relationship (Type, Print)	19b.	Mailing Addras	ss (Stree		Pural Route Numb	er, City or Town,	Stete, Zip Code)	
2.41.20	Man B. Kim - Son	7,7-1		-					land 20783	
Te, 1 and 1 sem other	20a. Method of Disposition		20b. Plece of	Disposition (Ne	eme of		Dete		City or Town, State	
Baltimore, semit. Pages 1 ar Department of Nea mportant: if Item; any Injury or other size.	1 Durial 2 Cremation 3 C			y, cremetory or Memor:			1-23-99	Olney	Maryland	
Baltim permit. Pa Department important: any injury ance.	21. Signaturerol Funera Gervice Licer		NOTDECE			ess of Fecility	1-23-33	orney,	Haryrand	
B P P P P P P P P P P P P P P P P P P P	M/10)	1		Hines-	Rina	ldi Fune	ral Home	Inc.	1 10000/	
	Pert1. Enter the disease, of com shock, or heart feilure. List only	plications that caused	the death. Do r	ot enter the mo	New ode of dy	Hampshir ing, such es cardi	e Ave., ac or raspiratory a	rrest,	pring, MD 20904	
Physician	shock, or heart feilure. List only	one ceuse on each lin			Intarval Between Onset and Deeth					
/Medical	Immediate Ceuse (Finel								1 day	
Examiner	disease or condition resulting in death) Dua to (or as a consequence of):									
ةِ السَّاسِةِ				ury tra		infection	N.			
68760, ifficate be executed g physician and es the burial-trensit edical Examiner	Sequentially list conditions,									
6 exe urial-a	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): C									
ficate be expression is the burial Edical E	Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of):									
2 00		d								
Bo ath contract of use		0.								
P.O. BOX hat the death cent d by the attendin leteched for use Physician/N	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying	cause g	iven in Pert I.	23b. Did	b. Did tobacco use contribute to the cause of death?		
F.O. BOX requires that the death cer requires that the death cer ween signed by the attendir hould be deteched for use eted by PhysicianA							10	1 Yes 2 No 3 Probably 4 Unknow		
() 100								en autopsy rmed?	24b. Wera eutopsy findings available prior to completion of cause of death?	
The law ate has the page 2 s							10	Yes 2 No	1 ☐ Yes 2 ☐ No	
r Vital Ri ysician: The I ysician: The I is certificate he director, page fo Be Com	25. Was casa referred to medical exeminar?						eeth (Check only	one)		
Physic at this care and direct the care and	1 ☐ Yes 2 ☑ No	Hospitel: 1 to Inpatie	nt 2 ER/Ou	patient 3 C	NOA		Home 5 ☐ Resi			
VISION OF VITA Attending Physicien: r death. ector: After this certific by the funeral director, iffication: To Be (27. Manner of Death 1 Natural 5 Pending 2 Accidant investigation	28a. Data of Injur (Month, Day		ime of njury M	28c. Inju We 1	uryat ork?]Yas 2∐No	28d. Describe	be:		
DIVISION C tall or Attanding P is after death. at Director: After t led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicida determined	28a. Piece of Inju						Street and Numb wn, Stete)	per or Rural Route Number,	
DIVISION Of To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director and the funera	29s. Cartifler (Check only one) (Check only one) (Check only one)	ysician: To the best of niner: On the basis of end menner ste	exemination and	daath occurred for invastigation	d at tha t n, in my	ima, data and plac opinion, daath occ	ce, and due to the curred at the time,	cause(s) end ma data end place, s	anner as stated. and due to the cause(s)	
o the omple omple	29b. Signature and title of certifier 29c. License number							29d. Date signed	d (Month, Day, Year)	
- 31-6	Chan she		D43496				Jan 21 1999			
	30. Name and address of person who Mohammad Khalid	completed cause of de			ver	Spring M	d 20910			
State Registrar	31. Date filed (Month, Dey, Year)	32. Registre	r's Signatura	4. 1						



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 13,1999 **Physician** Sara Hannah Kirk 04:25pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 27,1928 Birthplace (State or Foreign Country)
 PA. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2♥F Yrs **Director** 201-24-0200 70 Usual Residence of Decedent 10a. Stele 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director 208-1 MONTGOMERY MD. SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Norres 23a Funeral 10311 INSLEY ST. 20902 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marilal Status permit. Pages 1 and 2 should be filed within 72 hours after. Dopartment of Health and Mental Hygiene. Important: If Nem 27 is merked other than "matural", or Ne any Injury or other treatments event, the Medical Examine. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 RET .- OPERATOR C.&P. TELEPHONE CO. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 AKE BRUCE ELLIS HANNAH 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRY K. KIRK/HUSBAND AS ITEM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) IMLER VALLEY CEMETERY 1/17/99 IMLER, PA. 21. Signeture of Funerel Service Ligensee 22. Name and Address of Facility 20910 MOOO91 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 23a. Part1. Enler the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Metastatic Endomaterial Cancer Immediate Cause (Final disease or condition resulting in death) /Medical 34000 **Examiner** Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760, physician s the buria Due to (or as a consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Alexan signed to Records, 24b. Were autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autoosy 1 Yes 2 DNG 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 1 mpatient 2 ER/Outpetient 3 DOA 1 Yes 2 LNO edical Certification: To 28a. Dale of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 1 Nelural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - Al home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-33224 Jan 14,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 W Edmonston Dr Suite 303 Rockville, Md 20852 Ram S. Trehan MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

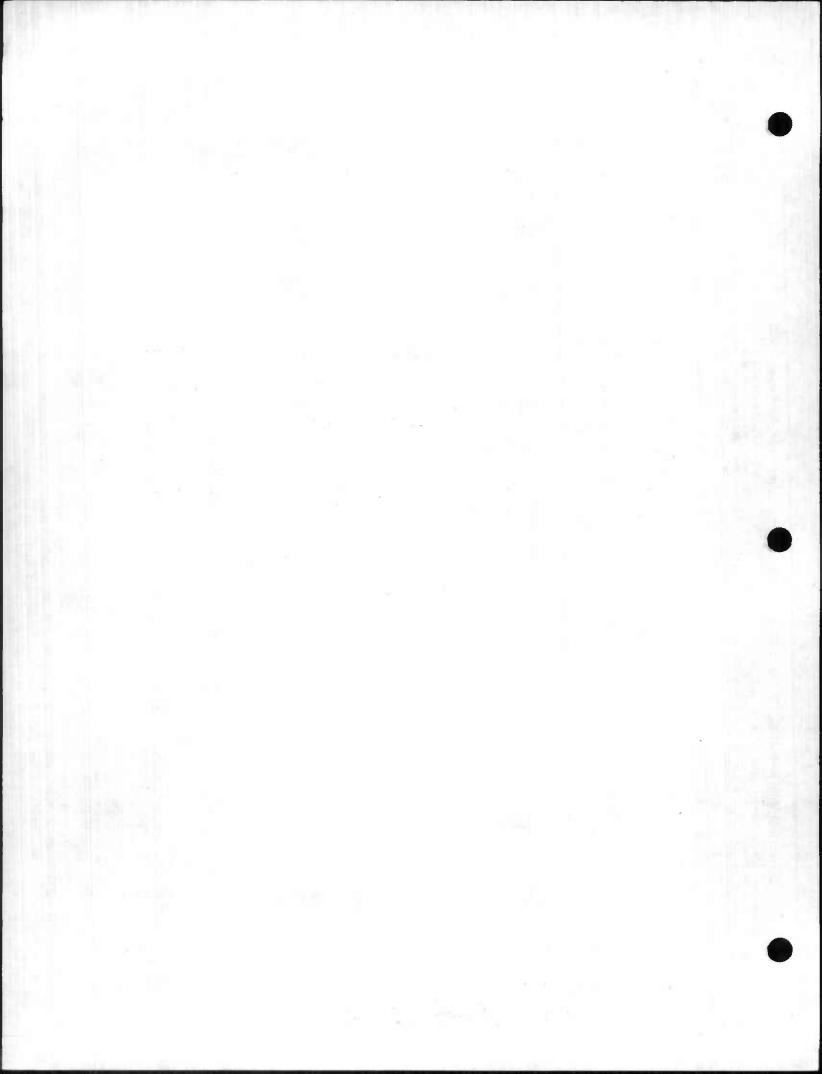
JAN 19 1999

State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Yvonne L. Kistner 2:30 AM 1999 18, January /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sunrise Independent & Assisted Living Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 10, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 TF 80 Yrs 434-09-7666 1918 Director Louisiana Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19310 Club House Road 20879 USA Funeral deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 Widowed 4 Divorced White Year or Dales: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health end Mental Hygiene Important: If Hem 27 is marked other thu any Injury or other traumatic event, tra-Electronic Assembly Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be William Leissinger Mary Ellen Whalen 19a. Informant's Name/Relationship (Type, Print) (husband) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19310 Club House Road, Gaithersburg, MD Henry P. Kistner, Sr. 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 1/20/99 Rockville, MD 22. Name end Address of Facility Francis J. Collins Funeral 21. Signeture of Funeral Service Licensee 500 University Blvd. West Home, Inc. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Coronary years Examiner Due to (or es consequence of). Examiner aucoma physician and s the burial-transit be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): Dementia Box 68760 neimers Physician/Medical Due to (or es e consequence of): attending for use as 88 Step arthritis Severe ears ned by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably 4 Unknown signed l Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To this 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of After 5 Pending investigation 1 Neturel n 24 hours after death.

Ne Funeral Director: Aft
pletaly filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier Albulta 20 1999 D.31391 danuary 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) Suhair Abulfarag, M.D., 481 N. Frederick Avenue, Gaithersburg, MD 20877 31. Date filed (Month, Day, Year) JAN 20 32. Registrar's Signature State

Registrar



State of Maryland / Department of Health and Mental Hygiene] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month January 12, 1999 11:55 AM Harvey James Klassen 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Washington Adventist Hospital/Care-Link Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 1 ₺ M 2 □ F 28, 1926 South Dakota 72 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? IISA 1605 Oaklawn Court 20903 14. Raca - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, atc 1 XYas 2 No If Yes, Give Yaer or Dates: 1944-46 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) Weather Service Meteorologist 18. Mothar's Name (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) John Klassen Emma Westfall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) (wife) 1605 Oaklawn Court, Silver Spring, MD 20903 Joan L. Klassen Pleca of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 5 Other (Specify) John's Cemetery 1/16/99 Silver Spring, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd. West Home, Inc. Camsei Silver SPring, MD 20901

He death. Do not enter the mode of dying, such as cardiac or respiratory errest 23a. Part1. Enter the disease, or complications that caus shock, or heart feilure. List only one cause on each METASTATIC THIROID CANCER Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 3 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en autopsy completion of cause of death? 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending 1 Yes 2 No investigation

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Physici<u>an</u> /Medical Examiner

Physician

- /Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a

permit. Pages 1 end 2 should be filed within 72 hours after deeth i Department of Health and Mental Hygiena. Important: If flem 27 is marked other than "natural", or frams 23 any injury or other traumatic event.

Baltimore, Maryland 21215-0020

with the Maryland r 28a-f show inotified at 5. Social Security Number

513-18-5766

10e. Street and Number

20a. Method of Disposition

oper

4 Donation

Immediate Cause (Final disaase or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

1 Yes 2 No

6 Could not be determined

27. Menner of Death

Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

29b. Signature and

4 Homicide

11. Marital Status

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Examiner Physician/Medical 98 USB ò Completed pega 2 Be 0

physician and s the burial-transit signed by the a has certificate After this funeral eftar deeth. Director: Af 24 hours e Hospital

Division of Vital Records, P.O. Box 68760.

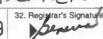
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To the within 2

Registrar

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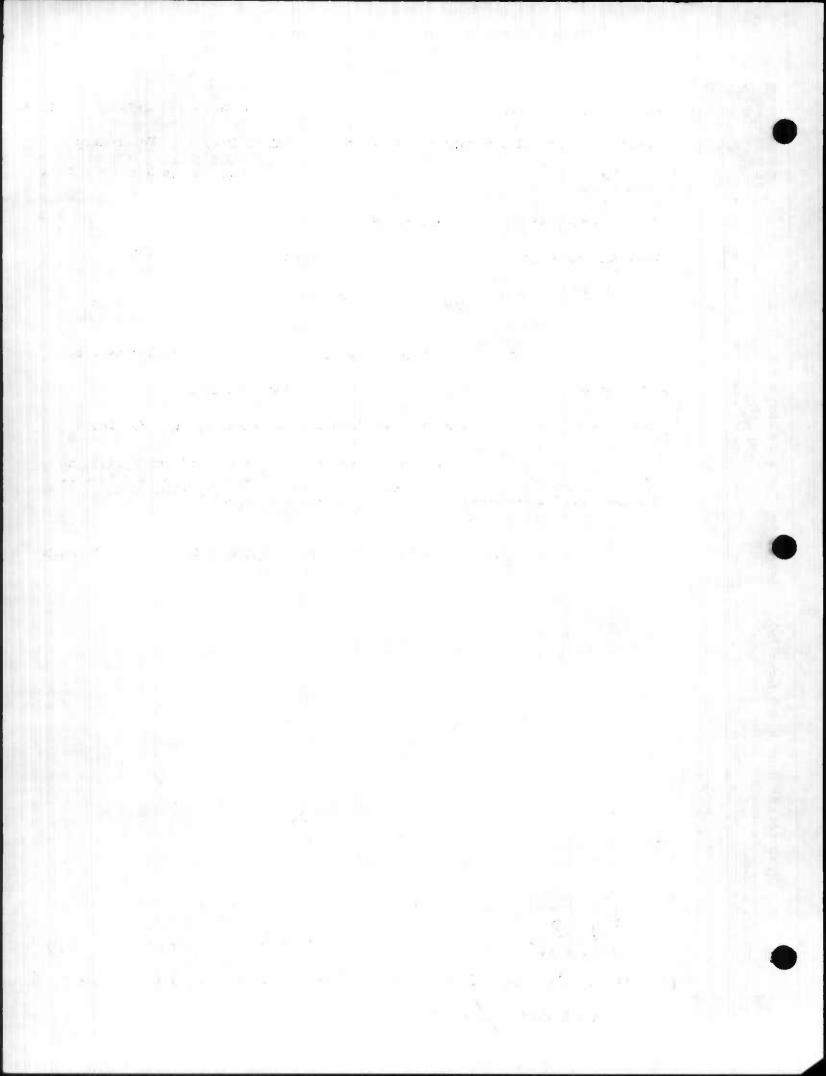
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

m 23a) (Type, Print) LOCKWOOD DRIVE, SILVERSPRING 20901

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 03/563

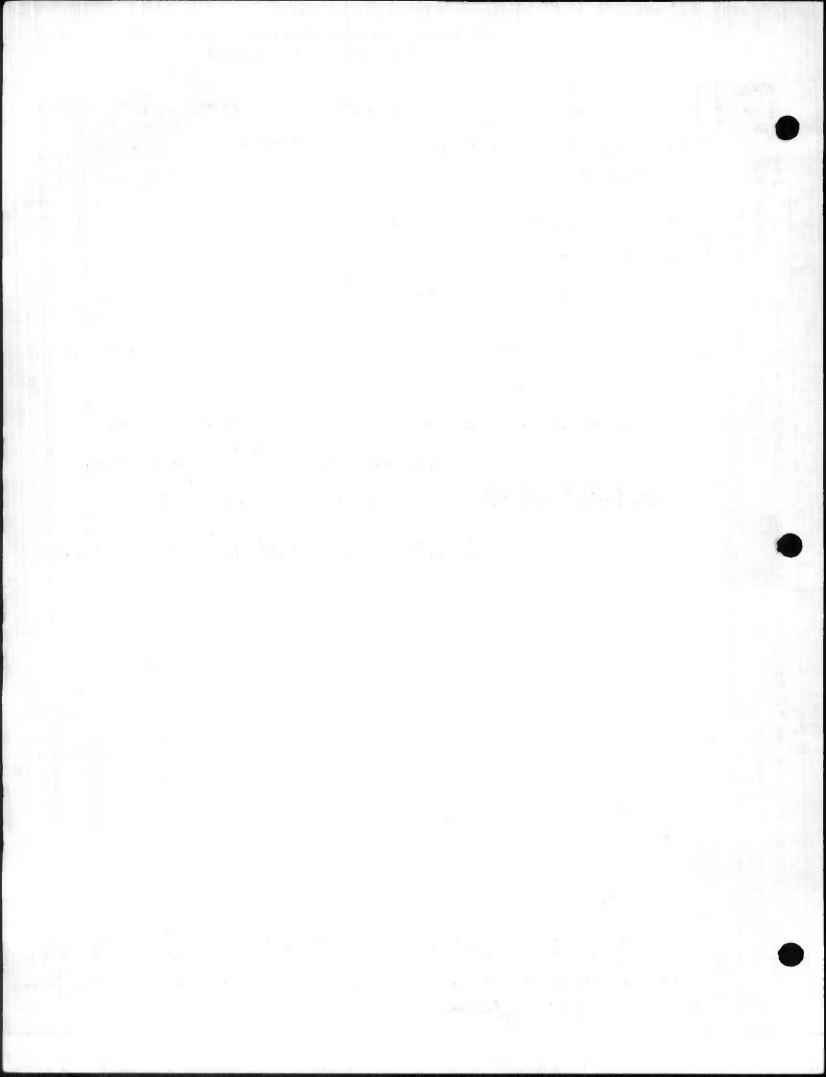


State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath **Physician** KOSTICK ADAM JANUARY 17, 1999 10:08 AM /Medical 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daeth 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Yaar 5. Social Security Number If Undar 24 Hrs. 7. Aga (In yrs. last birthdey) Birthplaca (State or Foreign Country) **Funeral** Days 1₩ 2□ F Months Hours 210-18-8074 Yrs. Director 73 10, 1926 Pennsylvania Usual Rasidanca of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic evant, it has been interested to notified. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director Maryland Montgomery Rockville 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 520 Veirs Mill Road Completed by Funeral 20852 United States 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Black, White, atc. 1 Tyes 2 No 1944— If Yes, Giva Year or Datas: 1946 1 Mavar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 1946 White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ Priest Roman Catholic Church 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be John Kostick Rose Sesatch 19a. Informant's Name/Reletionship (Typa, Print) Pers . Rep., 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zlp Coda) Rev. Msgr. William J. English P. O. Box 29260, Washington, 20b. Placa of Disposition (Name of cematary, cramatory or other pleca) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Removal from Stata Jan. 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 1999 Silver Spring, MD 21. Signature of Funeral Service Licensas 22. Name end Addrass of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final Kumtes disaasa or condition resulting in daath) Examiner Dua to (or as a consequanca of) Examiner siclan and buriel-transit or Attanding Physician: The law requires that the death cartificeta be axecuted Sequantially list conditions, if any, leading to immadiata causa. Enter Undartying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): physician s tha buriel P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): ate has been signed by the attendin page 2 should be deteched for use Part II. Other significant conditions contributing to death but not rasulting. In the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24a. Was an eutopsy performed? 24b. Wara autopsy findings available prior to completion of cause of daath? 2 No certificate director. 25. Was casa rafarrad to madical 26. Placa of Daeth (Check only one) exeminar? 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 No 1 Inpatiant this funaral 28a. Deta of Injury (Month, Dey Year) 27. Mannar of Deat 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Aftar 5 Panding invastigation Natural 24 hours ettar daath. 1 ☐ Yas 2 ☐ No within 24 hours efter death To the Funeral Director: , completely filled in by the 2 Accidant 6 Could not be datamined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicide Hospital edical Cartifying Phyaician: To the best of my knowledga, deeth occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and place, end due to the causa(s) and mannar stated. 29a. Certifian (Check only one) å 29b. Signature and titla of certifiar, 29c. Licansa number 29d. Data signad (Month, Day, Year) 10 cause of death (Item 23e) (Type, Print) MS Medical Center Dr. Pock MCGIELVY Ihon 31. Data tiled (Month, Day, Year) JAN 19 1999 32. Pagistrar's Signatura State Registrar

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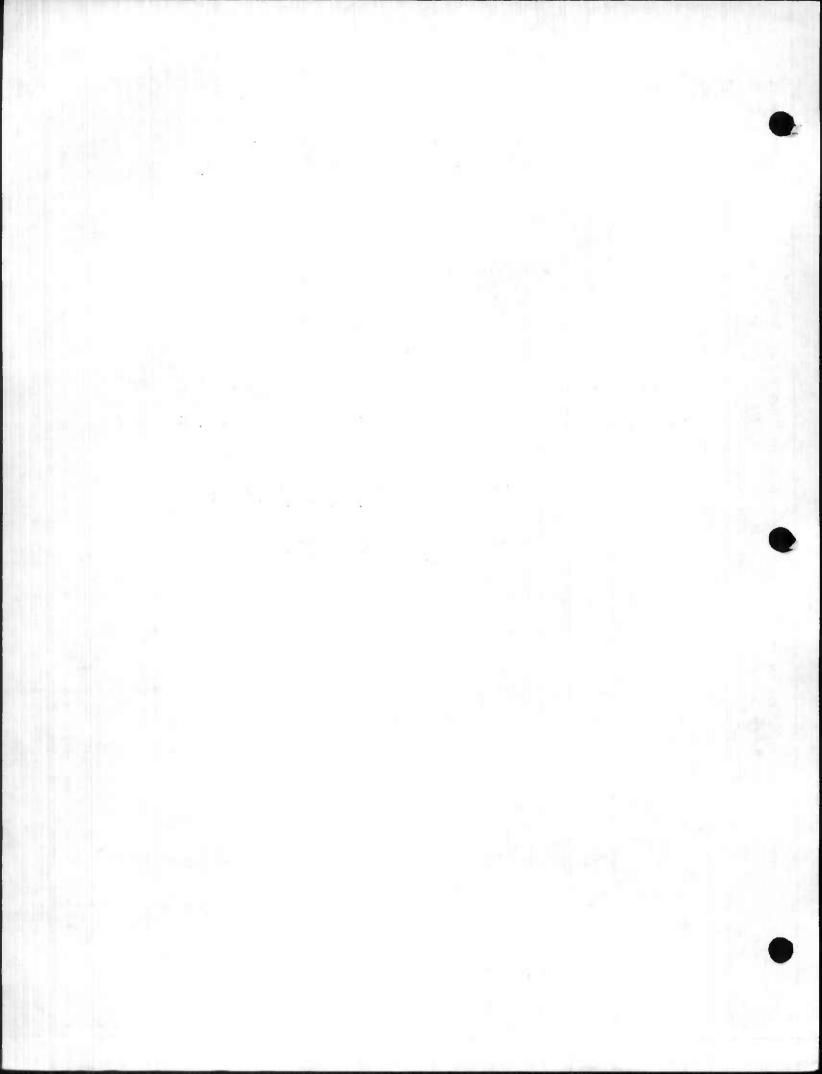
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 9 0 2 5 9 1

			Ce	rtificate of	Death		Re	eg. No.	UZ	1667	
	1. Decedent's Name (First, Middle, L	ast)				2.	Date of Deat	h	More	3. Time of D	eath
Physician	Unrighting L. Koufrie Hongary 16 1999										
/Medical Examiner	4a Facility Name (if not institution, g	iva street and number)			4b. City, To	own, or Locati		1	ty of Death	9:47	111
LABITITIES	Mariner Healt	h @ Circle Mar	or		Kensi	ngton		Mor	ntgome	erv	
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or 28a-f s be notified Director	MD Montgome	ery	Kensir	10f. Zip Code			1 44	0- 04	What Carr	(0	
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Eram by F	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 Yas 2 No If Yes, Give Yaar or Datas:		1 ☐ Yas 2X No			arr, 610.)	Speci		ite	
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mit in	4 Donation 5 Othar (Spec	ity) Ga	te of I	leaven Ce	meter	y 1/1	9/99 S	ilver	Sprin	ig, MD	
Repartmen mportant: my injury 8058.	21. Signature of Funeral Service Lice		2:	2. Name end Addr	ess of Fecili	y Fran	cis J.	Colli	ns Fu	neral	
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To the Funeral Directory filled in Medical Cert	29a. Certifier Check only one) Certifying P	hyalcian: To the best of my kr miner: On the basis of examir end manner stated.	nowledge, death nation and/or in	h occurred at the t vestigation, in my	ime, dete en opinion, dea	nd place, and ath occurred e	due to the ca et the time, da	ause(s) and mate and place	nanner as s , and due to	tated. the cause(s)	
within 24 hours a To the Funeral (completely filled Medical Ce	29b. Signafure and title of certifier	M A	1	29c. Licen	sa number		25	9d. Data sign	ed (Month	Day, Year)	
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	Xanno, M	p- ///			5102	0		1/19/9	7		
	30. Name and address of person who	completed cause of deeth (Ite	em 23a) (Type,	Print)	- 1	10 11	0.4.41	1 - 1	LAF)	_
	JEANNE P. A.	SNEE MD 37	20 FA	OKKNG11	1 11	/E KI	JUS/N	670N	TIL	2089:	5
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature /	1							
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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () mend #12,1/22/99,BMW,Montg.Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Physician Jan. 15, Monroe William Karmin 1999 3:00PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner 4932 Sentinel Dr. #101 Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 M 2 F Yrs. 076-22-1900 Director Sept. 2, 1929 New York Usuet Residence of Decedent 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No Montgomery Bethesda Director 2 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? must be n 4932 Sentinel Dr. #101 20816 U.S.A Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1.2 Yes 22. No If Yes, Give 1950 – Yeer or Detes: 1953 then "natural", or liems the Medical Examiner my Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indien. Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. ent. If item 27 is marked other then "1 Elementery/Secondery (0-12) College (1-4or 5+) Journalist News 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Stanley A. Karmin Phyllis Appelbaum 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mayanne Sherman Karmin-Wife 4932 Sentinel Dr. #101, Bethesda, MD 20816 20b. Plece of Disposition (Name of cemetery, cremetory or other plece)
Baltimore Washington 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Buriel 2X Cremetion 3 ☐ Removal from State Department o Important: If I any Injury or once. = 8 4 ☐ Donetion 5 ☐ Other (Specify) 1/20/99 Laurel, MD 22. Name end Address of Fecility 21. Signature of Funerel Service Licensee Joseph Gawler; s Sons INC., 5130 Wisconsin Ave. NW., Washington, DC 20016 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) 1 year Metastatic Adenocarcinoma Examiner Due to (or es e consequence of): Examine physician and the bunal-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): BS nse ed by the a 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 ☐ Yea 2X No 3 ☐ Probably 4 ☐ Unknown Emphysema signed I by 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy parformed? Completed page 2 has 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No certificata Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28d. Describe how trijury occurred 27. Menner of Deeth 28b. Time of 28e. Dete of tnjury (Month, Dey Year) 28c. Injury et Work? Certification: After 1 Neture 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident n 24 hours after dea ne Funeral Director nlately filled in by th 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Ptece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 6 Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medicai pletely (Check only one) To the To the To the Complet

State Registrar

Gary H. Miller MD., 31. Dete filed (Month, Dey, Yeer) **JAN 20**

H

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30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signeture and title of cartifier

Gar

32. Registrer's Signeture

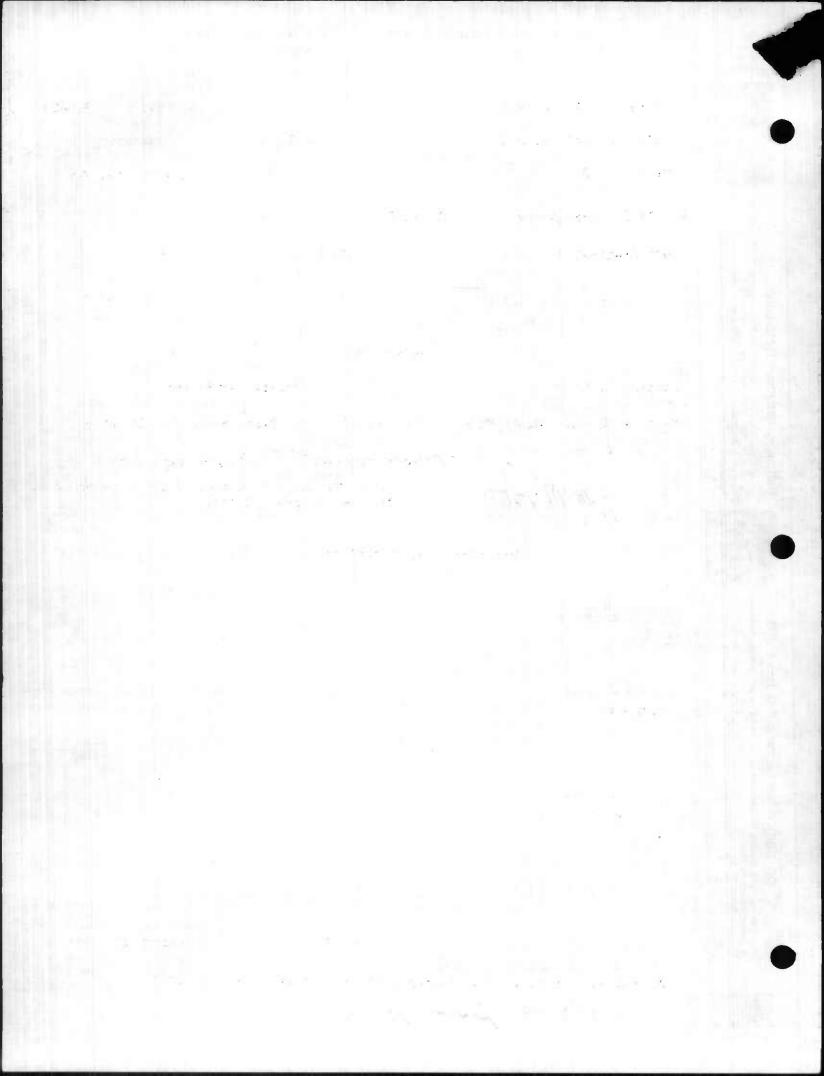
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29c. License number 13325

2440 M Street NW #810, Washington, DC 20037

29d. Date signed (Month, Dey, Year)

January 19, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** JANUARY 16, KAFKA FRITZ 1999 8:00 AM /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3201 UNIVERSITY BLVD. WEST APT. #22 KENSINGTON MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March 25, 1908 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□ F AUSTRIA Yrs. 064-16-7001 90 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show the Maryla 1 Yes 2 □ No MARYLAND MONTGOMERY KENSINGTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or edical Examiner must be r 20895 3201 UNIVERSITY BLVD. WEST APT. 22 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Ves 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced r than "natura Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 UNITED STATES Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. STATISTICIAN GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumeme) 88 ould be Mental 7 is marked or traumatic ev RICHARD KAFKA IDA ADLER es 1 and 2 should b of Health and Ment 7 Nem 27 is marked ir other traumatic e 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat end Number or Rurel Route Number, City or Town, Stete, Zip Code) BEATRICE KAFKA (WIFE) 3201 UNIVERSITY BLVD. W. #22-KENSINGTON, MD. 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Pages 1 Department of Hi Important: If Ner any Injury or off 1 Burial 2 XCremation 3 Removal from State MT. COMFORT CREMATORY 1/20/99 ALEXANDRIA, VIRGINIA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liq 22. Name end Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only ona cause on each line. Approximata Interval Between Onset and Deeth **Physician** Immediate Causa (Finel disease or condition resulting in death) /Medical PULMONARY EDEMA 1 HOUR Examiner Due to (or as a consequanca of): Examiner SEVERE MILTRAL REGUIGITATION 5 YEARS physician and the burial-transit the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as e consequença of): **Physician/Medical** Due to (or es e consequenca of): resulting in deeth) Lest Inding pl for by the e Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL INSUFFICIENCY, ATRIAL FIBRILLATION by 24b. Were autopsy findings evailable prior to complation of cause of daath? Completed VENTRICULAR TACHYARRHYTHMIAS, PROSTATE CANCER certificate has b 1 ☐ Yes 2 ☑ No RENAL CELL CANCER 1 ☐ Yes 2 No 25. Was casa rafarred to medical examiner? Be 26. Placa of Daath (Check only ona) TO . Hospital: Othar: 4 ☐ Nursing Home 5 ☑ Residenca 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 26b. Tima of 28c. Injury at Work? After 1 XNatural 5 Pending efter death. Director: Aft 1 Tes 2 No Investigation 2 Accident 6 Could not be detarmined 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide ò pelli Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceusa(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi edical (Check only 29b. Sign and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 10) 10 D33159 JANUARY 18, 1999 30. Name end address of parson who complated cause of death (Itam 23a) (Type,

Registrar

Baltimore, Maryland 21215-0020

Box 68760.

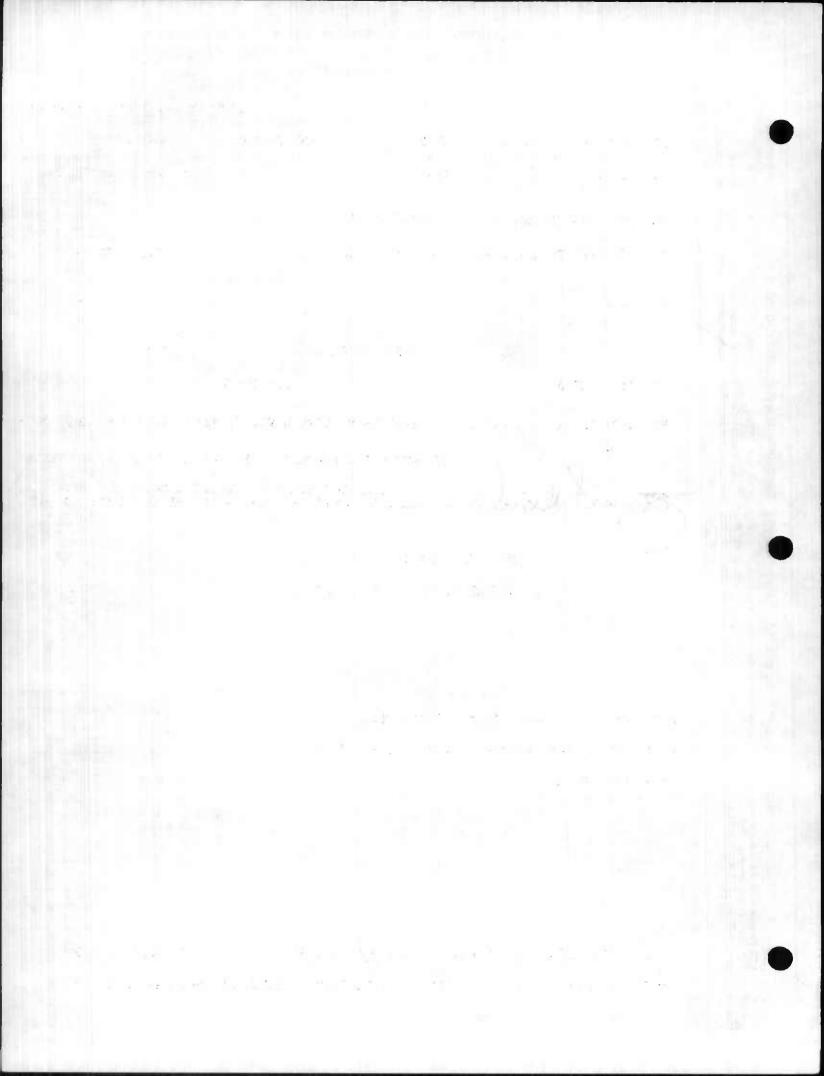
Records,

Division of Vital

31. Date filed (Month, Day, Year) JAN 19 1999 32. Registrar's Signatura

RUTH KEVESS-COHEN - 8700 GEORGIA AVENUE #400 - SILVER SPRING, MARYLAND

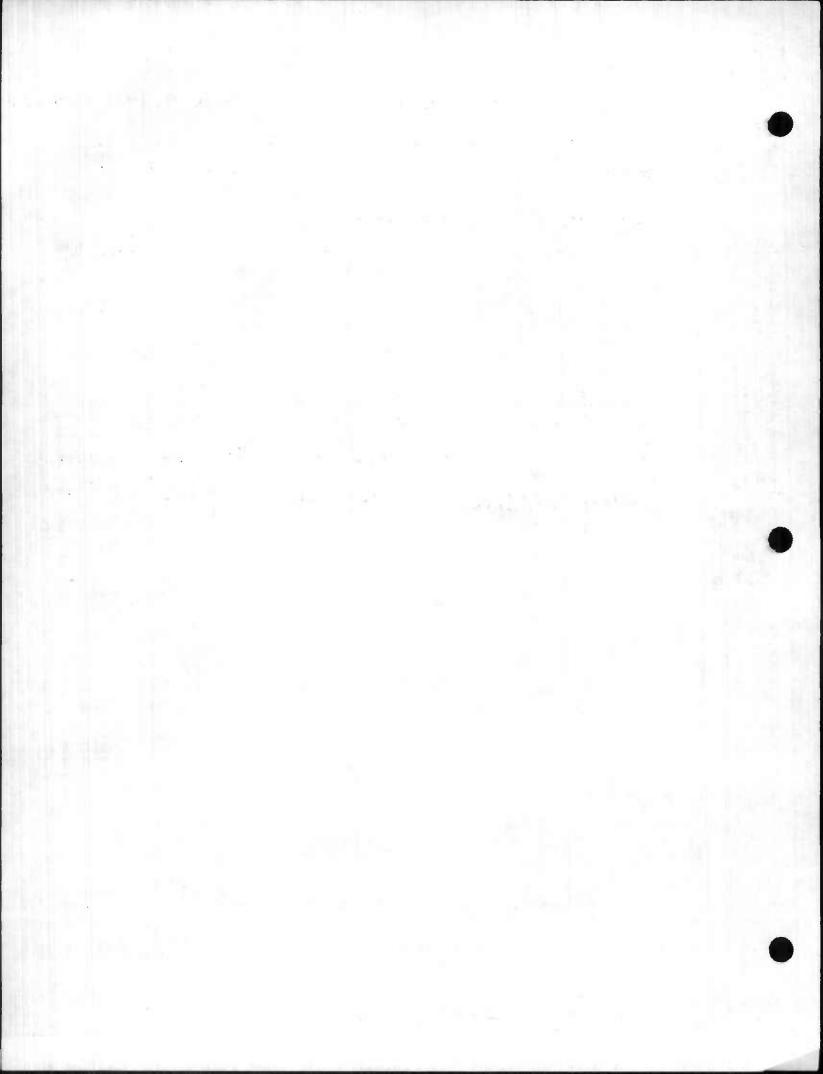
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State of Maryland / Department of Health and Mental Hygiene 9 0 2 5 9 L

		Cel	uncate of	Dealli		Reg. No.	
1. Decedent's Nama (First, Middla, ysician ALICIA	BERNADETTE	KAMMER			2. Date of De Month JANUAR	Y 21, 19	3. Time of Death 12:10 A.M.
aminer 4a Facility Name (If not institution, SHADY GROVE SHADY GROVE 5. Social Security Number 6	ADVENTIST HO: Sex 7. Aga (In yrs.			Ab. City, Town, or L ROCKVILI If Under 24 Hrs. Hours Min.		MONTG	OMERY 9. Birthplaca (Stata or Foreign
tor 219-06-2217 Usual Rasidance of Decedant	1LJM 2LJF 22	115.			March	22, 1976	Maryland
10a. Stata 10b. County	10c. Cit	y, Town or Loc	cation				10d. Insida City Limits
Maryland Montgo	mery Bu	ırtonsv	ille			10g. Citizan of Wh	1 ☐ Yes 2 📉 No
			2086	6			
14209 Angleton T 11. Meritel Status 12 Never Married 2 Married	12. Was Decedent Ever in U	.S. 13. V			pecify Yes or No		States Amarican Indian,
3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give A Yaar or Datas:		Yes, specify Cub	tispanic Origin? (Sj an, Mexican, Puarti Specify:	o Rican, atc.)	Black, Specify:	White, atc. White
15. Decedant's (Specify only highest (16a. Deced	ant's Usual Occup	pation	kina	16b. Kind of Busi	inass/Industry
15. Decedant's (Specify only highest (Elementery/Secondary (0-12)	College (1-4or 5+)	Stud		during most of world)		Educa	tion
17. Father's Name (First, Middle, La	st)			18. Mothar's Nem	na (First, Middle	Maidan Sumama,)
Thomas Kamme	rer			Linda	Du	ılln i g	
19a. Informent's Name/Ralationship		11.000 11.000		end Number or Ru			
Linda Tucker, M			Watkins sition (Nama of	Meadow I			
20a. Mathod of Disposition 1 □ Burel 2 ☒ Cramation 3 4 □ Denation 5 □ Other (Special Control of the Control of	□Remova#from State	ematery, crem	itan Cre		Jan 25, 1999		ity or Town, State
21. Signature of Funeral Service Lo	ensed	22.	Nema and Addra	ss of Facility	DeVo	1 Funera	1 Home
1 Janes	N.71	10	E. Deer	Park Dr	., Gaith	ersburg,	MD 20877
Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last	b	or as a consequ	uance of):	chage			S day
Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants	C	er as a consequ	uence of):				
that inflated evants rasulting in death) Last	Due to (o	r as a consequ	uance of):				
					1		
Part II. Other eignificant conditions	contributing to death but not ras	ulting in the un	iderlying cause gr	ven in Pert I.			ribute to the cause of death?
Part II. Other eignificant conditions						an autopsy ormed?	24b. Wera eutopsy findings eveilable prior to completion of cause of death?
					10	Yas 2 No	1 ☐ Yas 2 ☐ No
25. Was case refarred to medical examinar?				26. Place of Dee	th (Check only	one)	
O 1 Yes 2 No		ER/Outpatient		4 LI Nursing H		danca 6 □Other	
27. Mannar of Death 1 X Netural 5 Pending 2 Accident invastigat		28b. Time of Injury	M 28c. Inju	y at rk? Yes 2 □ No	28d. Dascribe	how injury occurre	d
3 Suicide 6 Could not determine	28a. Pleca of Injury - At he building, etc. (Specification)		eet, fectory, office		28f. Location (City or To		r or Rural Route Number,
29a. Certifier 1 Certifying I	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at tha tir estigetion, in my o	me, data and place ppinion, death occu	, end due to tha rred at the time,	cause(s) and man dete and place, ar	nar es stated. Ind due to tha cause(s)
≥ 29b. Signatura end titla of certifier	11.	2	29c. Licens	se number		29d. Data signed	(Month, Day, Year)
Mathr	Monh	7	03	2683		January	21, 1999
30. Nama and address of person when Ma Ha = Mos.	H	7/23a) (Type, F	Physic.	nos la	4 1	oderille.	MJ 25858
ate 31. Date filed (Month, Day, Year) trar	32. Registrer's Signa	A.	Spore	N			



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V	Physici /Medio	an cal	1. Decedent's Name (First, Middle, Las MILDRED F.	KENNEY	(2. Dete of Des Month Januar	y 15,19	Yaar 999 07:	15pm
	Examin Funeral Director	er	4a. Facility Name (If not institution, giva CHARIES TOWN 5. Social Security Number 1. Social Security Number 1. Social Residence of Decedent	RETIREME	(In yrs. last birt		Year If Undar 24 Hrs. Days Hours Min.	•	BAL	MORE 9. Birthplace (State Country)	a or Foreign
Method Mandage	ns 23a or 28a-f ehow	Director	10a. State 10b. County 10e. Street and Number 711 M	aiden Choi	ce Lane	nsville	ode		I0g. Citizen of W	1 □ Y	City Limits
200	P 2	by Funeral	11. Marital Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Event Armed Forcas? 1 Yes 2 No If Yes, Give Yaar or Dates:		13. Was Dacadan If Yes, specify	A 2 B of of Hispanic Origin? (Spir Cuban, Maxican, Puerto No Specify:	ecify Yes or No- Rican, atc.)		A - American Indian, White, etc. White	
d 21215-0020	end Mental tygiene. Is marked other than "natural", or raumatic event, ina Medical Exam	Completed	15. Decedant's Edi (Specify only highest grad Elementery/Secondary (0-12) 17. Eather's Name (First, Middle, Last)	College (1-4or 5+)		Decedent's Usual (Give kind of work of life, DO NOT use)	done during most of works retired)		16b. Kind of Bus OWN Maiden Sumane	HOME	
Maryland	f Health end Mental Hyg Item 27 is marked other other traumatic event,	To Be	ROBERT W. F. 19a. Informent's Name/Relationship (7)	Pe, Prihi/	19b.	Meiling Address (S	C/ACA Street and Number or Run	HAS	ENFU	5	
e , 7	nent of Health ant: If Item 27 ury or other t		20a. Method of Disposition 20a. Method of Disposition 20a. Method of Disposition 21. Specify 21. Specify of Fundral September (Specify)	Removal from State		22. Name and A	ETERY	AB	DALLA: INERALI	Pa.	1157 18702 1 APEL
	nysician Medical xaminer	_	23a. Famt. Enter the disease, or complance, or bear failure. List only of immediate Ceuse (Finat disease or condition resulting in death)	Coron	lary.	or enter the mode o	of dying, such as cardiac of	or respiretory en	est,	Approxim Intervet E Onset an	Between
Box 68760,	bu	Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initialed avents resulting in death) Lest	o		onsequence of):					
P.O. B	ed by the atte		Part II. Other eignificant conditions con	ntributing to death but r	not resulting in	the underlying ceus	se given in Part I.			ribute to the caus	CO.
M; I dred Moss 687 I'me law requires that the death certificate	ste hes been signed page 2 should be de	Completed by						24e. Was e perfor	med?	24b. Were autops available pric completion of death?	or to
			25. Was case referred to medical axaminer?				26. Place of Deet!		as 2,ATNo	1 ☐ Yes 2	ES NO
of Vita	a this	2	1 ☐ Yas 2 ♣ TNo 27. Manner of Deeth	lospital: 1 ☐ inpatient 28a. Date of Injury	2 ER/Out				ence 6 Other		
Sion sending	eath. or: After the fune	Certification:	1 Natural 5 Pending Investigation 3 Suicida 6 Could not be determined	(Month, Day Y 28e. Plece of Injury building, etc. ('ear) In	М	Work? 1 ☐ Yes 2 ☐ No		treet and Numbe	r or Rural Route N	umber,
Hospital	within 24 hours after d To the Funeral Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of n ner: On the basis of ex end manner stete	camination and	death occurred at t /or investigation, in	the time, dete and place, my optnion, death occurr	and due to the c	euse(s) and men lete end plece, a	nar as stated.	e(s)
10 A 01	within To the		29b. Signature end title of certifier	MD			cleense number		_	(Month, Day, Year	
			30. Name end eddress of person who co	1		Type, Print)	14053 idea (ho	CATON	SVILLE, M	10	
	Star Registra	re.	31. Data filed (Month, Day, Year) JAN 191	32. Registrar's		4 1	rues (no	rce co	re c	468	
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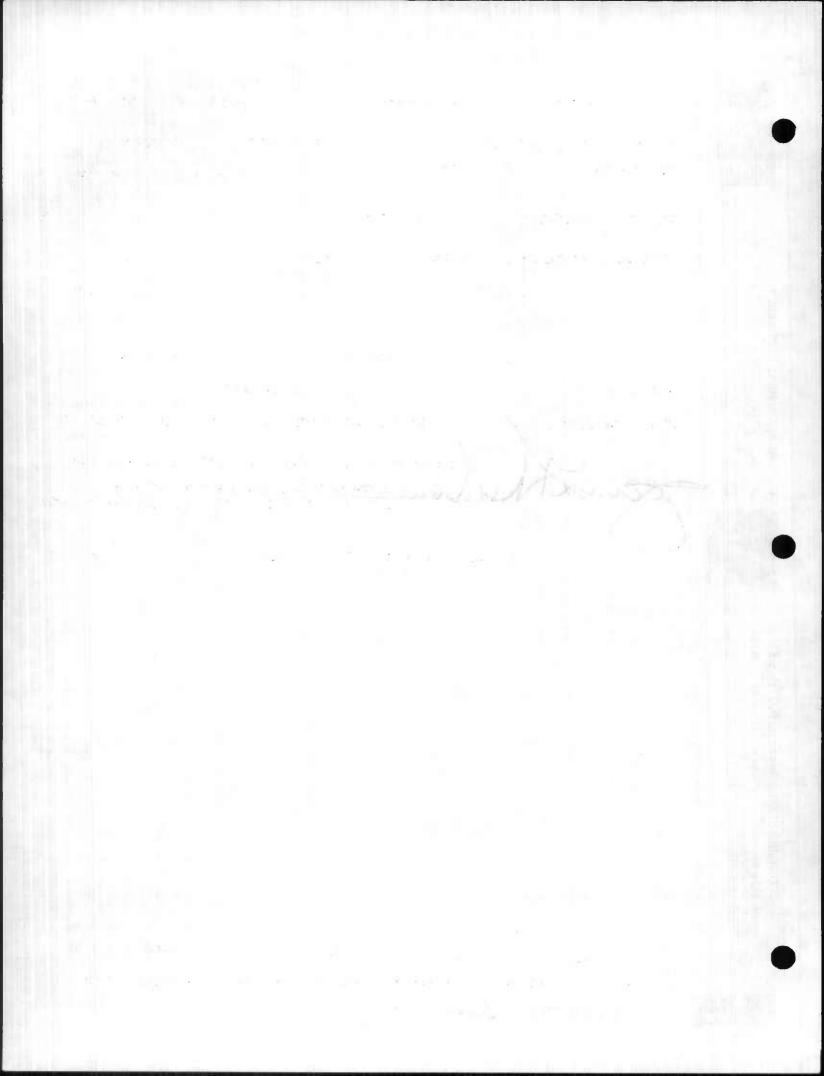
State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Daath 1. Decedant's Nama (First, Middla, Last) 3. Time of Deeth **Physician** JANUARY 16, 1999° LENTCHNER 9:55AM **FLORENCE** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner MONTGOMERY RANDOLPH HILLS NURSING HOME ROCKVILLE If Undar 1 Year If Under 24 Hrs. Hours Min. Birthplaca (Stata or Foreign Country) Social Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Deys 1 M 2 TF Months 85 057 50 5105 Yrs. Director TUNE 12 1913 **NEW YORK** Usual Residence of Decedent r ZBa-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryt 1 ☐ Yes 2 No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 than "natural", or herne 23e or the Medical Examiner must be 15115 INTERLACHEN DRIVE #923 20906 USA Funeral 12. Was Dacadant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indien. Black, Whita, atc. 2 should be filed within 72 hours after and Mental Hygisine. In marked other than "natural", or itse 1 ☐ Yas 2 ☐ No If Yas, Giva ♣ Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married WHITE 1 ☐ Yas 2 ☐ No Specify: Baltimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME traumatic event. 18 Mothar's Nama (First Middle Maiden Sumeme) 17. Fethar's Nama (First, Middla, Last) Be is marked ANNA MARVIN MILTON MARVIN 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) it. Pages 1 and 2 a strinent of Health an whant: If from 27 is n injury or other traus 7908 COACH STREET POTOMAC, MARYLAND LAURI JOSEPH/DAUGHTER Ob. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition tXI Burial 2 □ Cremation al from Stati 4 Donation 5 Other (Speed JUDEAN MEMORIAL GDN's. 1/18/99 OLNEY, MARYLAND glure of Funeral Sen 22. Nama and Address of Facility DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Intarval Between Onset and Daath Ph_{sician} /Medical du Cause (Final MONTHS disaasa or condition resulting in death) ADENOCARCINOMA OF UNKNOWN PRIMARY Examiner Due to (or as a consequence of) Examiner and-tran-Sequentially list conditions, if eny, leading to immediate causa. Entar Undarlying Causa (Disaasa or injury Due to (or as a consequence of): physician the burial Box 68760 8 Physician/Medical that initiated evants resulting in death) Lest Dua to (or as a consequence of): # attending 955 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. å signed by t d be detact 1 ☐ Yaa 2 No 3 Probably 4 Unknown Records. by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy periormed? Deen completion of cause of death? 100 page 2 1 ☐ Yas 2 No ate 1 ☐ Yas 2 ☐ No Division of Vital certifical Attending Physician: 89 25. Was case refarred to medical 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 funeral 28a. Data of Injury (Month, Day Yaar) 27. Mannar of Daath 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: After 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident after deall Director: 6 Could not be datamined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 T Homleida To the Hospital within 24 hours a To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signafure end titla of certifier D34032 JANUARY 18, 1999 2 and address of person who complated causa of death (fram 23a) (Type, Print) JEANNE P. ASHER, MD - 3720 FARRAGUT AVENUE - KENSINGTON, MARYLAND 20895 H. Data filad (Month, Day, Year) 32. Registrar's Signatura State

Darks

Registrar

JAN 20 1999



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** Andrew Calden Lloyd January 13, 1999 1500 /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11633 Lockwood Drive Silver Spring Montgomery 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1⊠M 2□F Yrs Director 577-18-4904 80 Washington, D.C. Usual Rasidance of Decedent the Maryland 10a Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits must be notified at 1 Yas 2 No Director Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 11633 Lockwood Drive #203 20904 Funeral USA death Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forcas? Biack, Whita, atc after 1 Yas 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 ₩ Widowed 4 Divorced Yaar or Datas White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondery (0-12) Coilege (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygient important: if flem 27 is marked other that any Injury or other traumette. Research Chemist International Fabricare 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be 2 Andrew Carroll Lloyd Camille Weber 19e. Informent's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 104 Quail Hollow Drive Andrew D. Lloyd (son) Dover, Delaware 19904 20b. Ptaca of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovei from Stela 4 Donation 5 Other (Specify) 1/18/99 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service License 22. Neme end Addrass of Fecility Francis J. Collins Funeral Home, Inc. amser 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enlar lha disaasa, or complications that of used the deeth. Do not entar the mode of dying, such as cardiac or respiretory arrest, shock, or haart failure. List only one cause of mich line. Approximata Intarvai Batween Onsat and Death **Physician** ATHEROSCUEROSIS /Medical Immediate Causa (Final diseasa or condition rasulting in death) YEARS Examiner physician end s the burial-transit that the death certificate be executed Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disaase or Injury that initiated events rasulting in daath) Last Due to (or es a consequance of): P.O. Box 68760 Physician/Medical Due to (or es a consequança of) Part If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 3000 3 3 Probably 4 Unknown bengis Records. by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yas 2 No 1 Yas 2 No certificate Division of Vital Hospital or Attanding Physician: 24 hours after death. Funerel Director: After this certifical stely filled in by the funeral director, 25. Was casa rafarred to medical axaminar? Be 26. Placa of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Panding investigation 1 Yas 2 No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida in 24 hour.
The Furneral Direction Certifying Physician: To the best of my knowledga, daeth occurred at tha tima, deta and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, deeth occurred at tha time, date and placa, and dua to the cause(s) and manner stated. To the Hosp within 24 hou To the Fune completely fil 29a. Certifier

State Registrar

31. Data filed (Month, Day, Year) **JAN 19**

29b. Signetura and Iitla of c

HAPLE

30. Nama and address of person

causa of death (Item 23a) (Type, Print) 32. Registrar's Signatura

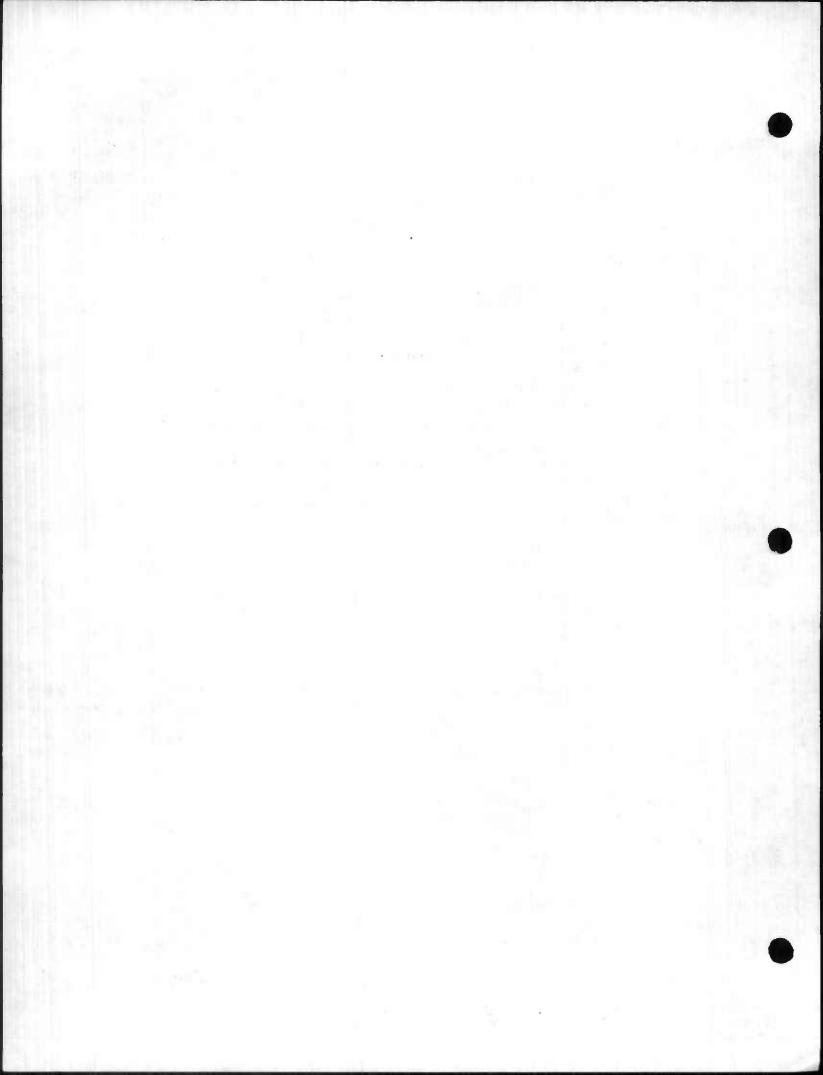
BENNER MO

29c. License number

31563

29d. Dela signed (Month, Dey, Year)

LOCKWOOD DRIVE SILVER



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time th 1 Decedent's Name (First Middle, Last) 2. Date of Death **Physiclan** 0. JAN. 13, 1999 10:15AM CHARLOTTE LOVENSTEIN /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner BARRON ST. 8701 TAKOMA PARK MONTGOMERY FEB. 19, 1918 If U r 1 Y r H Under 24 Hrs. Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2♥F Yrs. 80 VIRGINIA Director 220-32-5636 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 NYes 2 No Directo MD. MONTGOMERY TAKOMA PARK 10a. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code BARRON ST. 8701 #2 20912 U.S.A. Funerai filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced à WHITE "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NEVER WORKED NONE nd 2 should be filed value and Mental Hygie 27 is marked other in traumatic evant, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **OPPLEMAN** MALLIIW D. BERTHA SACHS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sr Department of Health and Important: If Item 27 is m any injury or other traum 209 S. TENNESSEE AVE., ATLANTIC CITY, N.J. 08401 LEONARD A. LOVENSTEIN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/14/99 RIVERDALE, MD. CHAMBERS CREMATORY 21. Signature of Funeral Service Licensee 22. Name end Address of Facility CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. MOOO91 23a. Part1. Enter the disease, or completely and the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) a CARDIAC ARREST Examiner Examiner MYOCARDIAL INFARCTION attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Lest Box 68760. ATTEROSCL EROSIS Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After or Attanding 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after deeth. investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homloide Hospital 29a. Certifier Medical 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. within 2 To the 1 the th 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 Edward 1-13-99 3 0-12703 ne and address of poston who completed cause of death (Item 23a) (Type, Print) EDWARD J. RICHARDS, M.D. GEORGIA AVE. #104, SILVER SPRING, MD. 20902 10301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ook **JAN 19** 1999 Registrar

DHMH 16 Rev 6/95

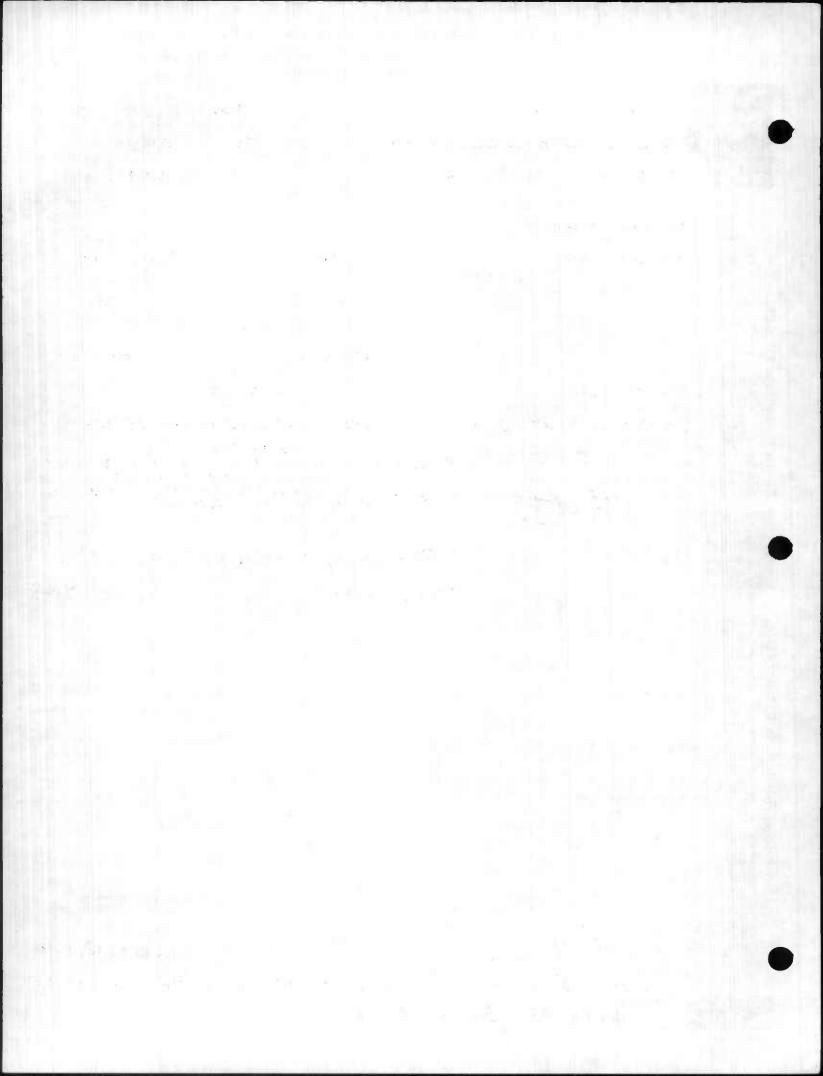
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\text{Q} \)

Certificate of Death 1 Decedent's Nama (First Middle Last) 2. Data of Daath 3. Time of Death Month **Physician** Lucille B. Lushine 15, 1999 January 9:50 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Shady Grove Adventist Nursing Center Rockville Montgomery If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Steta or Foreign Country) **Funeral** Months Days 1□ M 2☑ F Yrs 579-30-7863 **Director** March 20, 1910 Minnesota Usuel Residence of Decedant with the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1₺ Yes 2☐ No Directo Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2003 Dundee Road 20850 United States deeth 1 Funeral permit. Pages 1 end 2 should be filed within 72 hours effer dee. Deportment of Health end Mentel Hygiene. Important: if frem 27 is marked other than any injury or other traument. 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Rece - American Indien, Biack, Whita, atc. 11 Marital Status 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dataa: 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3 to Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) 4 Teacher Home Education 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Theodore Boyer Angeline Arness 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Angeline G. Braun/Daughter 2003 Dundee Road, Rockville, Maryland 20850 20b. Place of Disposition (Nama of cametery, cramatory or other place) Jan. 18, 1999 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01126 is thet causad the daeth. Do not antar tha mode of dying, such as cardiac or respiretory errast, Approximete Intarval Between Onsat end Daath ceuse on aech Physician /Medical Immediete Ceusa (Final disease or condition rasulting in death) Examiner Examine orgranus that the death certificate be executed physician end the buriel-transit Sequantially list conditions, if any, laading to immadiate causa. Enter Undarlying Causa (Disaase or injury Dua to (or as a onsaquance of): P.O. Box 68760. Physician/Medical that initiated avants rasulting in death) Last Dua to (or as a consequence of) 98 use 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yae 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, þ 24b. Wera eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate hes b 1 ☐ Yas 2 No Hospital or Attending Physicien: 25. Was case referred to medical axaminar? Be 26. Pieca of Daeth (Check only one) Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Mennar of Deeth 28h Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 5 Panding invastigation 1 Netural death. 1 Yas 2 No 2 Accident ofter deatl 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28a. Piaca of Injury - At homa, farm, straat, fectory, office building, atc. (Spacify) filled in by 4 Homicide 24 hours e 29a. Cartifiar 🗹 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and dua to tha causa(s) and menner as ateted. To the Hosp within 24 hor To the Fune completely fi edical 2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, deta end plece, end due to the cause(s) end menner stated. (Check only one) 29b. Signetura end Nie g 29c. License number 29d. Data signed (Month, Day, Year) JANUARY, 18, 1999 2 30. Name and addrass of person who a d cause of deeth (Item 23a) (Type, Print) · EDMONSTON DR. ROCKVILLE Swarow Kar 31. Data filed (Month, Day, Year) 32. Registrar's Signatura JAN 1 9 1999 Registrar

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State Registrar

DHMH 16 Rev 6/95

IAN 1 0 1000 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

B. Spark

O.C.M.E.

JANUARY 17,1999

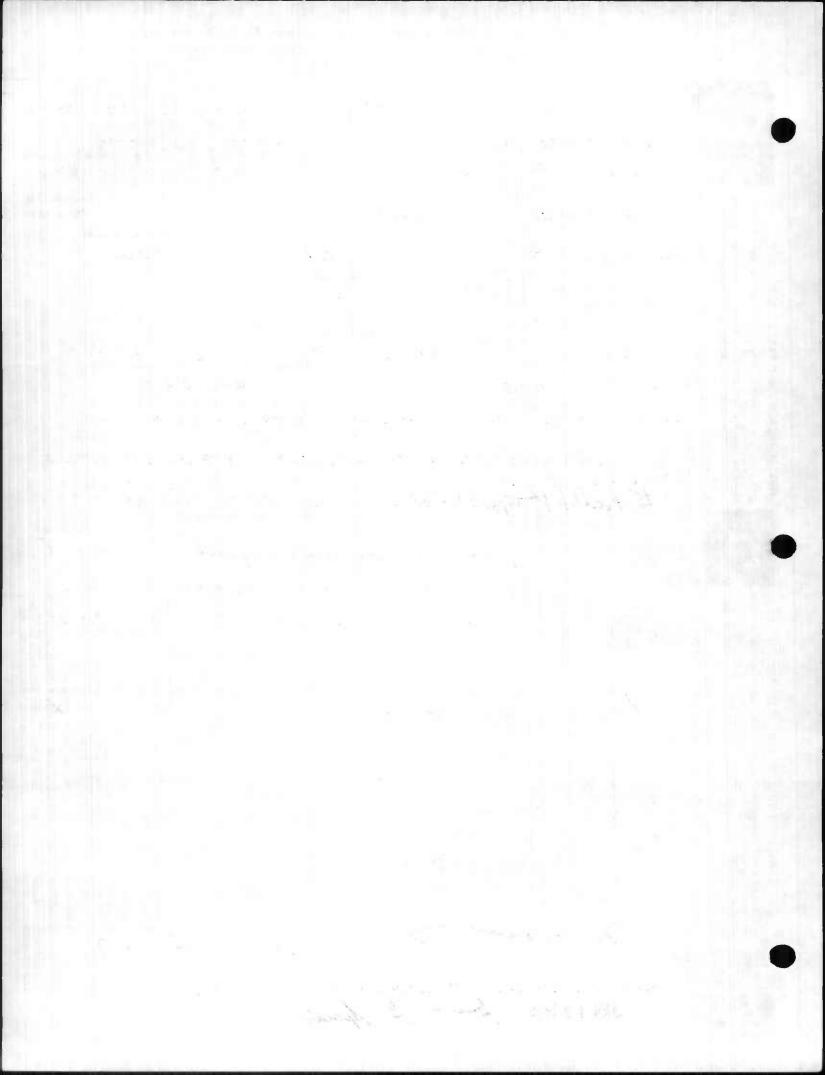
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31. Date filed (Month, Day, Year)

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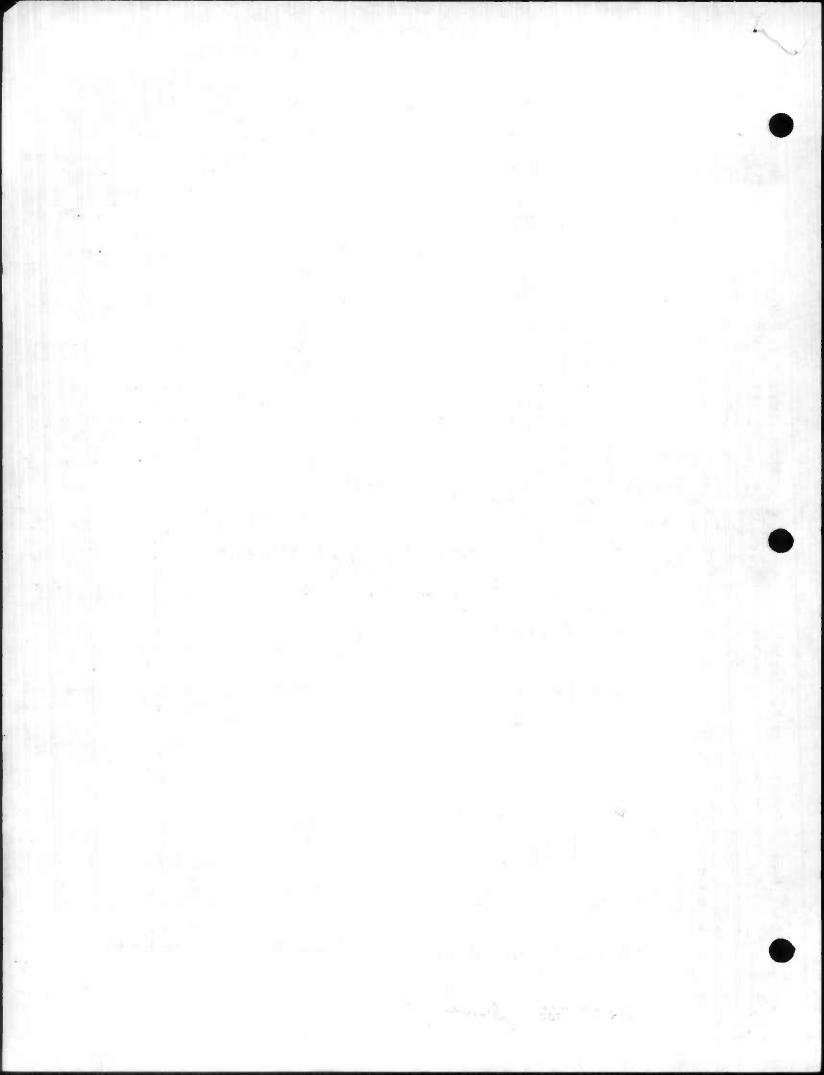


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State of Maryland / Department of Health and Mental Hygiene 99 02602

Certificate of Death

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V completely Medica	29b. Signetu N 30. Neme er		A KV	cause of death (Ite	m 23a) (Type,				•	3			10	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Harold William McCurdy, Sr. January 18, 1999 12:35am 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Shady Grove Adventist Hospital Rockville MD Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Dev. Year) Birthpiece (State or Foreign Country) Months Deys 11MM 2□ F 196-10-2130 July 31, 1916 Pennsylvania Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No PA Lancaster Lancaster 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 670 Gentry Drive 17603 United States 12. Wes Decedent Ever In U,S Armed Forces? Race - American Indian, Biack, White, etc. 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Yes 2 □ No If Yes, Give Year or Detes: WWII 1 Never Merried 2 Married 1 Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Machinist Technical Machinery 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Harry McCurdy Bertha 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 10300 Mystic Meadow Way, Oakton, VA 22124
e of Disposition (Neme of Dete 20c. Location - City or Tow H. William McCurdy, Jr. (Son) 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/21/99 Lancaster, Pennsylvania Riverview Burial Park 21. Signeture of Funeral Service Licente 22. Name end Address of Fecility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 Seit & 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Bivoutricular comporture Heart Faceline Immediete Ceuse (Finel diseese or condition resulting in death) MARIN WIN Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Restersen Few Y cody Due to (or es e consequence of) Pert II. Other significant conditions reputributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? enal declare on herro dialons 1 ☐ Yes 2 ☐ No 3€ Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural

Physician /Medicai Examiner The lew requires that the death cartificate be executed the buriel-frensit

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Pegas 1 and 2 should be filed within 72 ho nent of Haalth and Mantel Hygiane. ant: If item 27 is marked other than "natur ury or other traumatic event, the Maxical

permit. Pega Department of Important: If any injury or once.

Director

Completed by Funeral

Be

tha Maryland

deeth

21215-0020

Baltimore, Maryland

P.O. Box 68760.

Records,

of Vital

Division

or Attending Physician:

Hospital

Physician/Medical for usa es ð 8 page 2 should 10 24 hours after death.

Funeral Director: After this lefely filled in by the funeral of

director.

ylejejdmos

within 2 the

this

Examiner Be Completed Certification: Medicai

4 Homicide

28e. Dete of Injury (Month, Dey Year) 28c, injury et Work? 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be

1 Yes 2 No Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner steted. 29a. Certifier (Check only one)

Quas 29b. Signature and title of person

29c. License number D30112

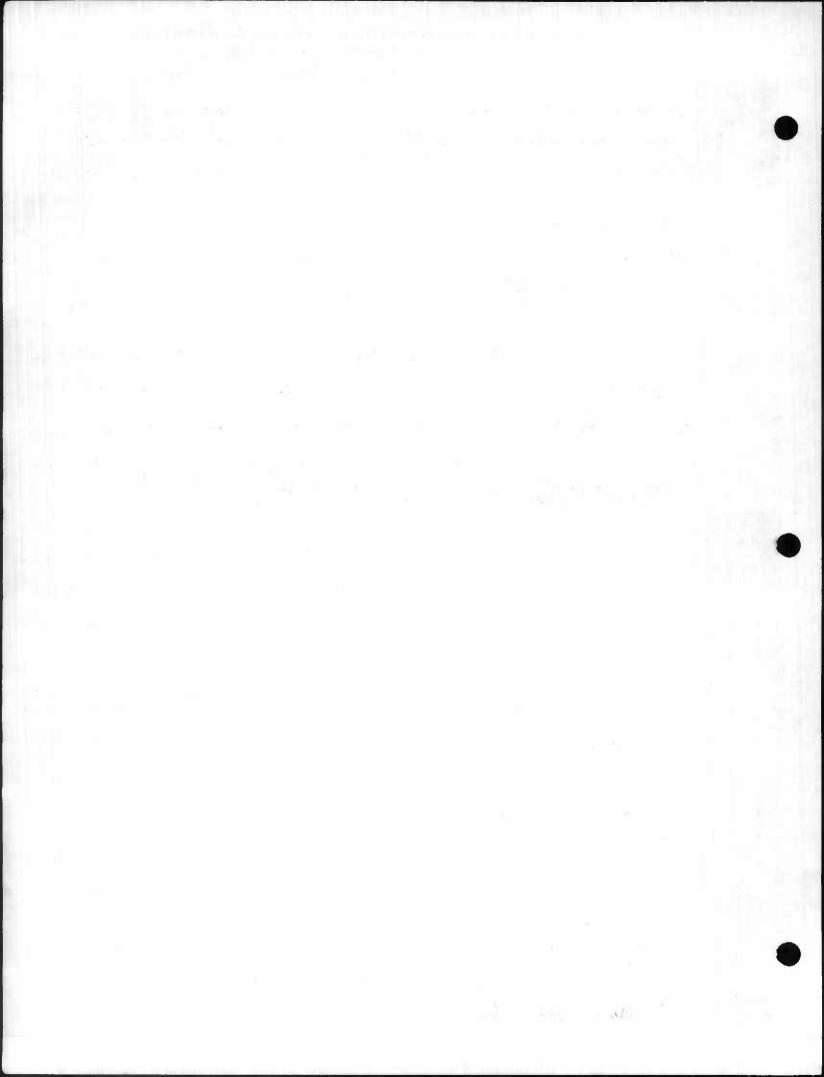
29d. Dete signed (Month, Dey, Year) JAN. 18 1999

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) V. SAXONAMO 7100 DEON CROSSING CT. BETHESOA

State Registrar 31. Dete filed (Month, Dey, Year)

JAN 1 9 1999

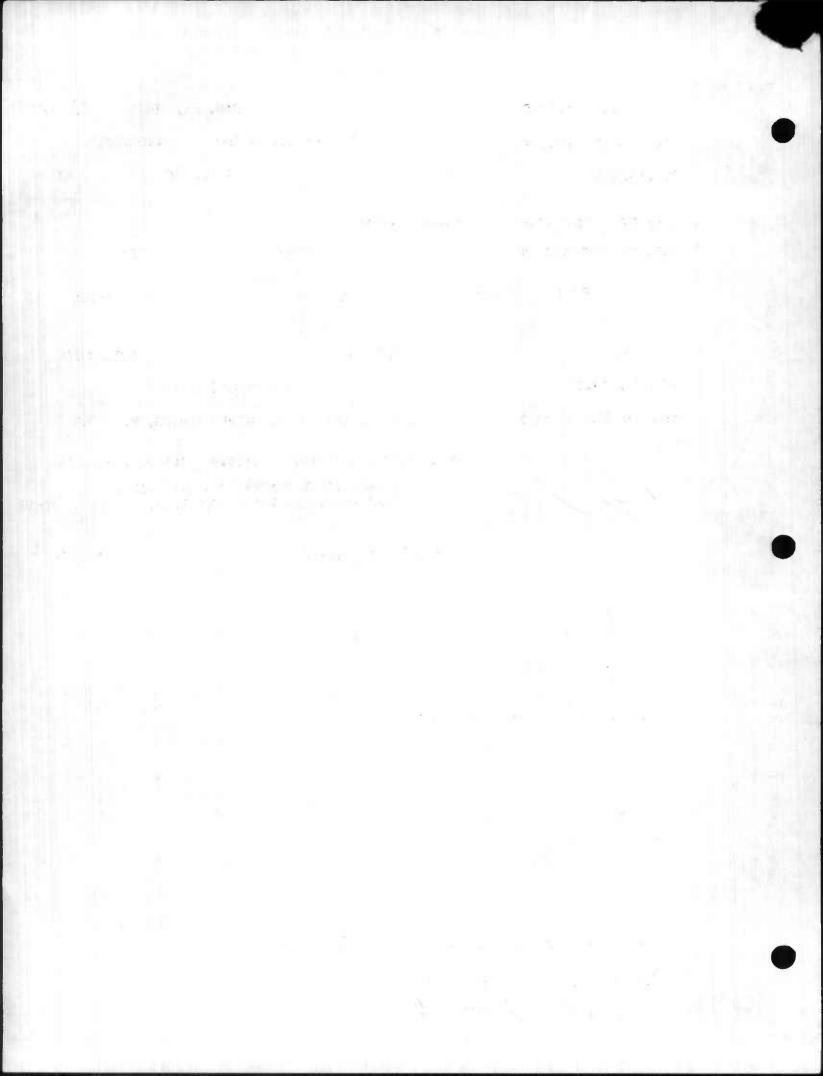
32. Registrar's Signature



Please Type or Print in Black Indelibie Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0

			C	ertificat	e of	Death			Reg. No.		, 12 0 0	
	1. Decedent's Name (First, Middle, La.	st)						2. Date of D		Va.		na of Death
Physicial /Medies	SOLOMON MELLI	ZER						JAN.	12, 1	999	8	: 1(oAt
/Medica Examine	An English blome of the net together them the	e streat end number)				4b. City, To	wn, or Lo	cation of Dea		County of De	eath	
	3906 BEL PRE RD.	, #8				SILVE	R SP	RING	M	ONTGO	MERY	
Funeral Director	5. Social Sacurify Number 6. S		(In yrs. lest birthda 75 Yrs.	y) If Unda Months			24 Hrs. Min.	8. Dafe of Bi (Month, Di 04.19	rth ey, Year) 1923	9. B		ate or Foreign
P	Usual Residence of Decedenf											
Marylan	MARYLAND MONTGON		SILVER S									de City Limits Yes 2 No
	MARYLAND MONTGON 10e. Street and Number 3906 BEL PRE ROAI) #8		10f. Zip	Code	20906	5		10g. Citizen of Whet Country? USA			
dea	11. Marital Stetus 1 Navar Married 2 Married	12. Was Decedent Ev Armed Forces?	er in U,S. 13	. Was Dece	dent of	Hispanic Orl	gin? (Spe	Bicen etc.)	0- 1	4. Race - Ar Bleck, WI	merican India	.n,
O20 ours after	3 ☐ Widowed 4 ☐ Divorced	1 Yas 2 No if Yes, Give Yeer or Dates:		_	35	Specify:	, 1 40110	, 110011, 010.7		Specify:	WHITE	
und 21215-0020 be filed within 72 hours af tal Hygiene. d other than "naturel, or event, the Wadical Energy event, the Wadical Energy	15. Decedent's Ec (Specify only highest grate Elementary/Secondary (0-12)	lucation de completed)	16a. Dec	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)					16b. Kln	d of Busines	ss/Industry	
with:	Elementary/Secondary (0-12)	College (1-4or 5+)		LESMAN		,,,				2777	O (O)	
d 2121 filed within Hygiene. ther than ord, the Ve			- OA	TINI JOHN	V	18. Mothe	r's Name	e (First, Middle	. Meldan S		OMOBII	ıt.
Maryland 2121 d 2 should be filed within th and Mental Hygiene. The marked other than "treumatic event, the text	JULIUS MELTZER							JNOBTAI				
_ SECT	19a. Informant's Name/Relationship (I							ILVER S			a, Zip Code) 20906	5
0 8027	20a. Method of Disposition 13XI Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Discemetery, c.	remetory or o	other ple		1.	Date 13.99			or Town, Ste	
Baltimo permit. Pag Department Important: II any injury o	21. Signature of Funeral Service Licen	see		EDWARD	SA		NERA	AL DIRE	CTION	,INC.		
Physician /Medical Examiner	fmmediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	ostate ue to (or as a cons			er					5 y	eard Death
ertificate be ling physicia	Cause (Disease or injury that initiated events resulting in death) Lasf Due to (or es a consequence of):											
daath daath e atta	Part II. Other elgnificant conditions of	ontributing to death but	not resulting in the	underlying	euse g	iven In Pert f		23b. Did	l tobacco u	iae contribu	uta to the ca	use of death's
5 60 .	Artemosc lenetic	Heart D	isease					1	Yes 20	KNo 3□	Probably	4 Unknow
	Completed b								s en eutops ormed?	sy 241	b. Were auto eveilable p completion of deeth?	prior to
The law ate has t	0							10	Yes 2	(No	1 🗌 Yes	2 No
sician: The sectificate director, pag	25. Was cese refarred to medicel					26. Place	of Deat	h (Check only	one)			
	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpat	ienf 3 D	DA O	ther: 4 Nu	irsing Ho	me 5 Res	idence 6	□Other (S)	pecify)	
Attanding Physical death.		28e. Date of Injury (Month, Dey)	(ear) 28b. Time	of A	28c. Inju Wo 1	ork? Yes 2		28d. Describe	how injury	occurred		
Invision or Attanding after death. Director: After d in by the fune	27. Manner of Death 17 Natural 2 Accident 3 Suicide 4 Homicide 2 Homicide 2 Rending investigation 6 Could not be determined	28e. Place of injury							(Street end own, Stete)	Number or	Rurel Route	Number,
Hospi 24 hou Funer taly fill	29a. Certifier 1 Certifying Ph	yelcian: To the best of a liner: On the basis of e end manner state	xamination and/or	eth occurred Investigation	at the t	ime, date en opinion, dea	d plece, th occurr	end due to the red at the time	cause(s) , date and	and manner place, and d	as stated. due to the cau	use(s)
within 2 To the comple	29b. Signafure and fittle of certifier	7		29	c. Licen	se number			29d. Date	signed (Mo	onth, Dey, Ye	ar)
10	1 Courts St	her m.	D		02	1910			Janu	ary 1	8, 199	79
	30. Mame and address of person who leter B. Sher	completed ceuse of dee	th (Item 23a) (Typ 3947	-	rrai	ra Di	٦,	wheat	on	mp	209	706
State Registra	DIAN TELIVINA	2. Regisfrar	s Signeture	Span	Ks	/						

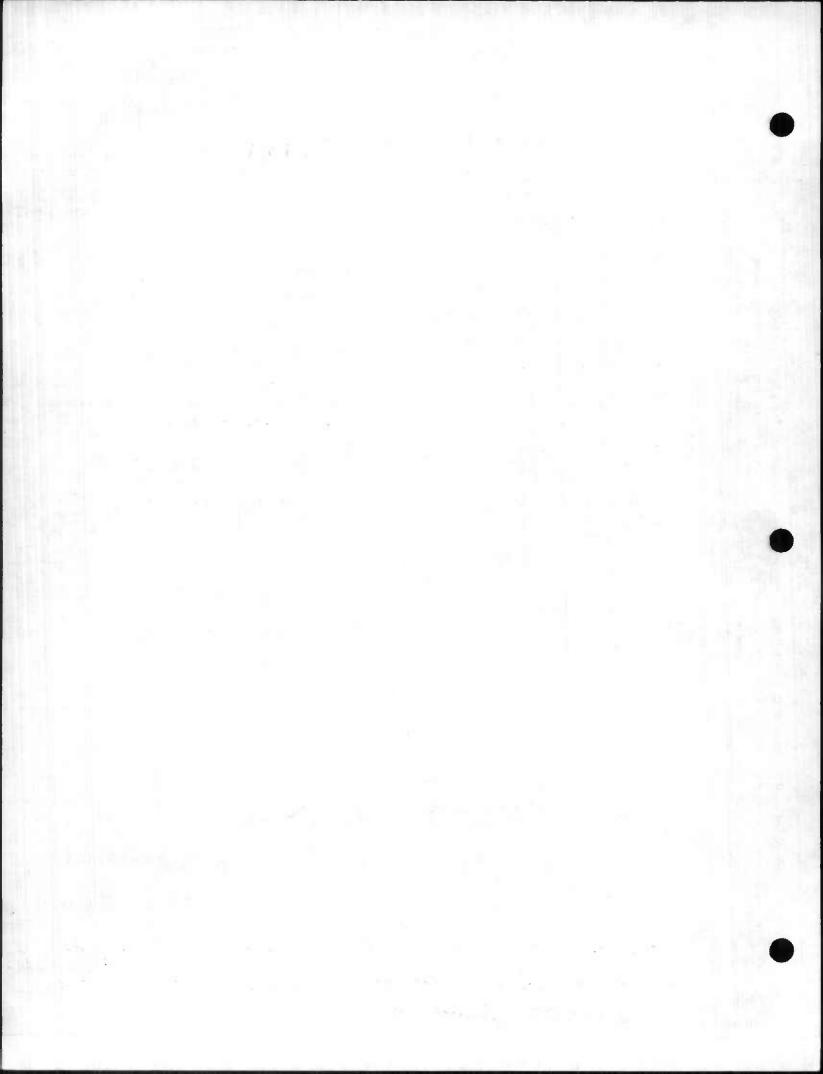


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State of Maryland / Department of Health and Mental Hygiene 9

					Cei	tifical	te of	Death			Reg. No.		
hysician	1. Decedent's Neme (First,	Middle, La	st)							2. Dete of Do Month	eath Dey	Yeer	3. Time of Death
cian lical	WILLIAM			MEN	DEL	-				JANUA			4:55 PM
niner	4e Facility Name (If not ins	titution, giv	re street end nu	ım <i>ber)</i>			4	6b. City, To	wn, or Lo	cation of Deal	h 4c. Coun	y of Death	
	MONTGOMERY	VILLA	GE CARE	& REHAB	ILITA	CION	M	ONTGO	MERY	VILLA	GE MON	TGOME	RY
	5. Social Security Number	6. 8		7. Age (In yrs. I		If Unde Months	r 1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D.	rth ay, Year)	9. Birth	place (Stete or Foreign ntry)
	106-10-5904		XM 20 F	96	Yrs.					Sept 2	9, 1902	Mass	achusetts
	Usuel Residence of Deced			10c City	Town or Lo	cation						1	10d. Inside City Limits
70													1 ☐ Yes 2 ☑ No
Funeral Directo		ntgom	ery	RC	ckvil.	1	0.1				40. 000		11
5	10e. Street and Number	1 5					Code				10g. Citizen of		
E .	12709 Robind	ale D			1.01		20853		1-1-0 (0-	-76 M	Unite		
5	11. Meritel Status	7.1.	Armed F			Yes, spe	cify Cuba	ispanic Or an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)		eck, White,	can Indien, , etc.
7	1 Never Merried 20		1 ☐ Yes If Yes, Gi Year or D	ive		☐ Yes	2 🔯 No	Specify	:		Speci	ity:	white a
		cedent's E		Zates.	16a. Deced	loot's Heu	al Occur	ation			16b. Kind of I		white
Completed	(Specify only	highest gra	ade completed)		(Give	kind of wo	ork done	during mos	st of worki	ing	TOD. KING OF	Jugii 1033i 11	no on y
-	Elementary/Secondary (6	0-12)	College ((1-4or 5+)		chini		,			Valv	e Wor	ks
,	17. Father's Neme (First, N	liddle, Last,)					18. Moth	er's Neme	(First, Middle	, Maiden Sume	me)	
200	Adalbert	Mo	ndel					Н	edwig	7	Les		
•	19a. Informent's Neme/Re				19b. Mailir	a Addres	s (Street				er, City or Town	n, Stete, Zii	p Code)
	Barbara Posn			hter							ille, M		0853
	20a. Method of Disposition		_,	20b. Pl	ace of Dispo	sition (Ne	me of			Dete	20c. Location		own, State
	1 Burial 2 Crem			Stete	Micha					an 21,	Untonf		Nor Vonl
	21. Signature of Funeral Si		-/-	DL.				ss of Fecili	ity	999			New York
	1 4	1	- ().						D		uneral :		
	- Jake	1 1	n. /1	a.							hersbur	g, MD	
	23a Part I Enter the disect or heart failure	List only	one cause on	each line.	. Do not ent	er the mo	de of dylin	ig, such as	cardiac o	or respiretory is	irrest,		Approximate Intervel Between Onset and Deeth
	Immediate Cause (Finel		0	20.10-0	1	1-	dus.	11-					. 10000
	disease or condition resulting in death)		a. CON	CONPMIN	M	Ser	4	1156	MS	<u>e</u>		-	URARS
9				Due to (or	de si conseq	uance of)							
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Medical Examiner	Sequentially list conditions if any, leading to immediate	ė		Due to (or	es e conseq	uence of)	•					1	
5	cause. Enter Underlying Cause (Disease or injury that initiated events	~	c	Dive to for									
3	resulting in death) Last	4.7		Due to (or	as e conseq	uence ot):							
3		-	d									-	
3	Death Other deathers	- 4144		Land by a second	6	4 4 4 4		1.5.4		L non Die	Ash		
Physician	Part II. Other significant co	manions c	ontributing to a	leath but not resu	iting in the ur	nderrying (cause giv	en in Per					to the cause of death?
										1	Yea 2 No	3 LI Pro	obably 🕬 Unknown
d by										24a. Was	an eutopsy		Vere autopsy findings
010											omed?	an	vailable prior to ompletion of cause
Completed												of	I death?
1										10	Yes 2 No	1	☐ Yas 2☐ No
	25. Was case referred to mexaminer?	edical	Hospitel:				Oct	00 0 0		(Check only			
0	1 Yes 2 No		10		R/Outpatien			4125(1)			idence 6 0		ify)
2	1 ANetural 5 □	Pending		of Injury oth, Day Year)	28b. Tima of Injury		28c. Injur Wor			zoa. Describe	how injury occu	111 9 0	
Certification:	Z D / NOCIOOTIL	ould not b		41-1		М		Yes 2□	7.1	006 Landin	(Change of and a)	hare P	rol Davida Abreston
	4 Homicide	letermined	200. Plack	e of Injury - At hor ling, etc. (Specify,		et, fector	y, office				(Street end Nun wn, Stete)	iber of Hul	ral Route Number,
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edicai	(Check only 2 Me	rtifying Ph dicat Exan	niner: On the b	best of my know asis of examineti	riedge, death on and/or inv	occurred	at the tin	ne, date er pinion, des	nd plece, of oth occurr	and due to the ed et the time,	date end place	nenner es : , and due !	stated. to the cause(s)
Med	one)		end men	nner steted.									
-	29b. Signeture and title of o	entitier	0	1 1.0		29	C. LICONS	e number	05		29d. Date sign		
	- Callid	A	Dove	_MD				SOC	12	-	JANUAR	Y 15,	1999
	30. Name and address of p	erson who	completed caus	se of death (Item	23a) (Type, 1	Print)							THE PERSON
	GABRIEL BERRI	EBI, 1	M.D., 1	5200 SHA	DY GRO	OVE R	OAD,	SUI	ITE #	305 R	OCKVILL	E, MD	20850
e	31. Date filed (Month, Day,			Registrer's Signet	ure /		-						
rar	JAN :	1 9 13	399	Our	Ø.	14	port	2					

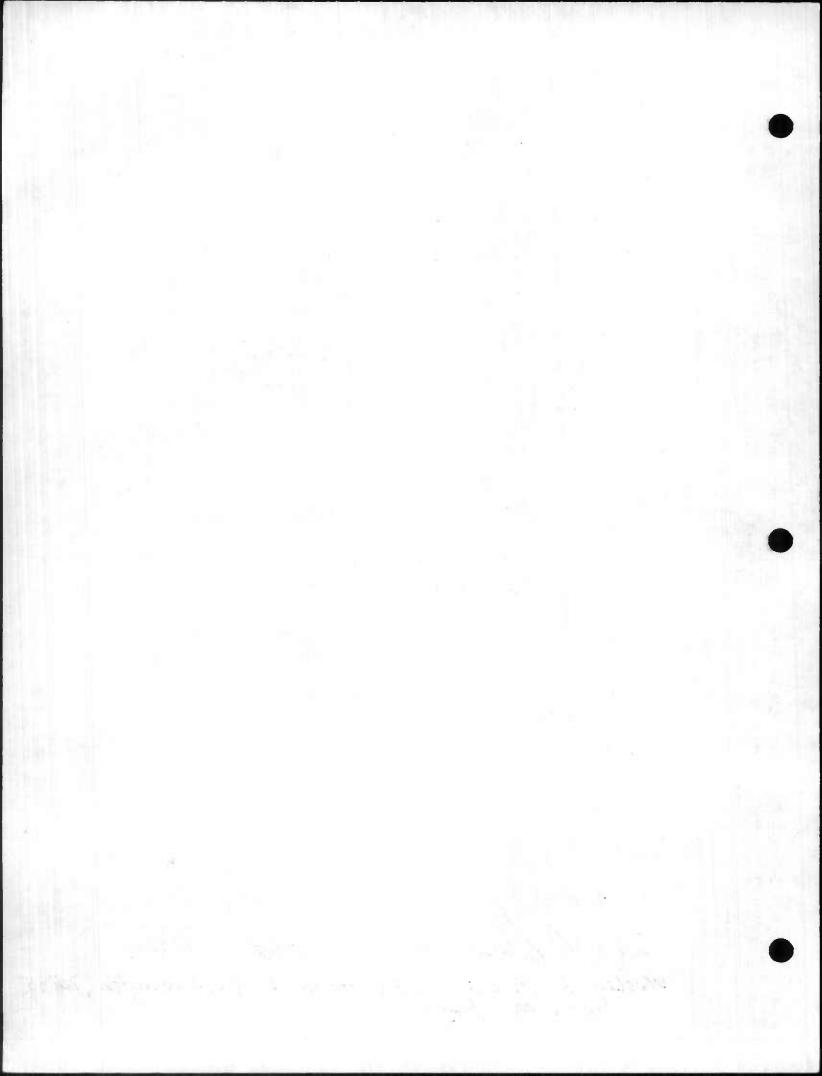
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Beg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day **Physician** Month January 19, 1999 5:50 PM George J. /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3333 University Blvd. West, Apt. 509 Kensington Montgomery If Under 1 Yaar | If Undar 24 Hrs. Months | Deys | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys 1⊠M 2□F 69 Director 051-22-0973 Oct. 9, 1929 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or items 23s or 28s-f show 1 ☐ Yes 2 ☑ No Director MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 3333 University Blvd. West, Apt. 509 20895 Funeral USA Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedant Ever in U,S. Armed Forcas? Race - American Indian, Bleck, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Yaar or Dates: 1948-52 1 Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: 1 ☐ Yas 2 ☒ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work dona during most of working
life. DO NOT use teiling)
Administrative Assistant to 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Union the President 17. Falhar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be permit. Pages 1 and 2 should be l Department of Health and Mental Important: If Nem 27 is marked of any Injury or other traumatic eve Anna Bizub Thomas W. Miller 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Richard J. Miller, Sr. (brother) 15 Meadow Lane, Rensselaer, NY 12144 20a. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, State cemetery, cremetory or other plece) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/23/99 Albany, NY Albany Rural Francis J. Collins Funeral 21. Signature of Funaral Service Licensee 22. Name end Address of Fecility Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23a. Part1. Entar tha disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one ceuse on aech lina. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Acute Myocardial Infarction disaasa or condition resulting in death) 1-2 hours Examiner Due to (or as e consequence of): Examiner Coronary Artery Disease vears physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditiona, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as e consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 2 Yes 2 □ No 3 Probably 4 Unknown diabetes mellitus Division of Vitai Records. þ 24b. Were autopsy findings available prior to Completed 24a. Wes en eutopsy performed? hypertension completion of cause of death? 1 ☐ Yes 2 ₺ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 1 ☐ Yes 2 ☑ No After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) illed in by 4 Homicide within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and grenner statad. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) +1 30. Neme and address of person who completed cause of deeth (flem 23a) (Type, Print) (0810 Connecticut Ave, Kensington, 20895 Wesley 31. Date filed (Month, Pey, Year) JAN 2 1 32. Registrar's Signature State Registrar

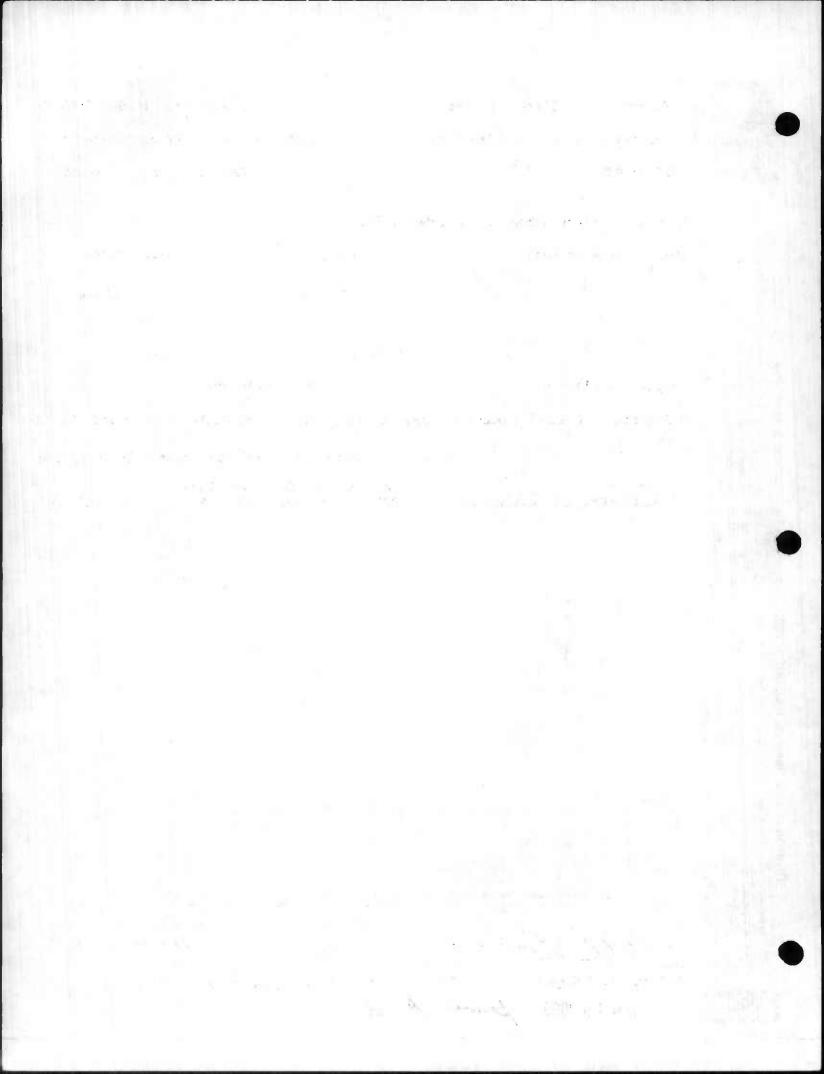
DHMH 16 Rev 6/95



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		1 Decodes to Name / First Middle Land				tificate of			Reg. No.		2607
Physici	an	1. Decedant's Name (First, Middla, Las		1				2. Data of Da Month	-	Yaar 999	3. Tima of Death
/Medic	al	Margaret McAll		Ler			11 On T	Januar			5:45 PM
Examir	ier	4a. Facility Nama (If not institution, give Collington Epis		Cama			4b.City, Town, o Mitchell	r Location of Death			,
		5. Social Security Number 6. S		(In yrs. last bi	inth alou (1)	If Undar 1 Yaar	If Undar 24 H		Princ		
Funeral Director			M 22 F	87	Yrs.	Months Days	Hours Mi		8, 1911	9. Birthp Coun Mar	laca (Stata or Fora try) yland
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28a-1	Director	Maryland Prince 10a. Street and Number	George's	Mitche	ellv						1 ☐ Yas 2√ N
with or a	급	10450 Lottsford R				10f. Zip Coda			10g. Citizan of V		-
s 23	erai	11. Marital Status	12. Was Decedant E	ues in 11 C	10.14	2072		10	Unite		
2 should be filed within 72 hours after death with the Maryland and Mental Hyglana. Is marked other than "natural", or items 23s or 28s-f show armstic event, the Modical Examinet must be notified at	by Funeral	1 ☐ Navar Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armad Forcas? 1 Yas 2 N If Yas, Giva Yaar or Datas:		13. Was Decedant of Hispanic Origin? If Yas, specify Cuban, Maxican, Pu 1 ☐ Yas 2 ☒ No Specify:			irto Rican, atc.)	Specify	e - Amaric k, Whita, Wh	
72 hc	ted	15. Dacedant's Ed (Specify only highast grad	ucation	16a	. Deceda	ant's Usual Occup	ation		16b. Kind of Bu	sinass/Inc	fustry
ithin	Completed	Elamantary/Secondary (0-12)	Collega (1-4or 5-	+)	lifa. D	ind of work dona O NOT usa ratire	during most of w d)	orking			
or th	50		2		Secr	etary			Bank		
should be filed within nd Mental Hygiana. marked other than matic event, the M	Be	17. Fathar's Nama (First, Middla, Last)					18. Mothar's N	ama (First, Middla,	Maidan Surnam	a)	
2 should to and Ment is marked raumatic	၉	Benjamin McAllist	er				Susan (Geoghegan			
d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Ralationship (7						Rural Routa Numbe			
1 and 1 Health arm 27 i		Elizabeth C. Engl	ish (daught					Federalsb	urg, Ma	rylar	nd 21632
pemit. Pagas 1 and Department of Health Important: If Item 27 any Injury or other to		20a. Mathod of Disposition 1 Burial 2 Cramation 3 DI	Removel from State	20b. Place o	f Disposi ry, crama	ition (Nama of atory or other plac	ce)	Data	20c. Location -	City or To	wn, Stata
permit. Pagas Departmant of I Important: If Ita any Injury or of ance.		4 Donation 5 Othar (Spacify				ke Crema		1-18-99	Beltsvi	11e,	Maryland
Departs Imports Imports Info		21. Signatura of Funaral Sarvice Licens 23a. Part1. Entar tha disaasa, or comp shock, or haart failura. List only company the company of the	Dalm	tha daath. Do	Ra 9:	33 Gist	ral Serv Avenue,	vices, P. Silver S ac or raspiratory ar	pring.	Maryl	and 209 Approximata Interval Between Onsat and Daath
nysician /Medicai Examiner		Immediata Causa (Final disaasa or condition rasulting in daath)	Myocardi	al Infa	arct	ion				m	inutes
Mark I	ē			Dua to (or as a							
nsit	듩		Coronary							5	years
rificate be axecuted ig physician and as the burial-transit	ai Examiner	Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury	C	oua to (or as a	consequ	ance of):				1	
certificate be axecuted ding physician and sa as the burial-transit	Medicai	that Initiated avants rasulting in death) Last	d	ua to (or as a	consequa	ance of):					
death cert e attending ed for usa	ciar										
tha d	Physician/M	Part II. Other eignificant conditions con	ntributing to death but	not rasulting l	n tha und	larlylng ceusa giv	an in Part I.	23b. Did to	obacco use con	tributa to	the cause of deati
as the	þ							1 🗆 Y	′•• 2X No	3 Prob	ebly 4 ☐ Unkno
a faw require has been sig ga 2 should b	Completed							24a. Was a perfor	an autopsy med?	con	ra autopsy findings ilabla prior to nplation of causa laath?
cata ha								1 🗆 Y	as 2 ∑ No	1 🗆	Yas 2X No
ysician: The	Be	25. Was casa rafarred to medical axaminar?	Paramitant:					ath (Check only or	na)		
this raidi	lon: To	27. Mannar of Daath 1 🖾 Natural 5 🗆 Panding	1 Inpatian 28a. Data of Injury (Month, Day	28b.	rtpatient Fima of njury	28c. Injun Work	4 AL Nursing	Homa 5 Rasid)
or Attending after death. Director: After In by the funa	Certification:	2 Accidant Invastigation 3 Suicida 6 Could not ba 4 Homicida datamined	28a. Place of Injurbuilding, atc.	y - At homa, fa (Specify)	rm, straa		Yas 2 □ No	28f. Location (S City or Tow		er or Flural	Routa Number,
	edicai Ce	Medical Exami	nician: To the bast of a	my knowledga	, daath o	occurred at the time	na, data and plac	e, and dua to tha c	ausa(s) and mai	nnar as sta	ited.
the the	-		and mannar state	ad.		-					
		29b. Signature and title of certifie	1/1//	in		29c. Licansa	number	2	9d. Data signed		Pay, Year)
3		· WILL I	M3	NU		D 47	603		1/18/99	-	
		30. Nama and address of person who of									
1 - 2 - 4		William F. DuBoyo	e, M. D.,	79 Ke	tter	ing Driv	ve, Uppe	rMarlbor	o, MD 2	20774	
Stat Registra	٠,	JAN 1 9 1993	32. Pegistrar	s Signatura	4	Look					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Evelyn H. Mohn January 14, 1999 6:11 PM 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number Birthplaca (State or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) 1□M 2⊠F Yrs. 84 577-46-8752 Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 201 Upton Street 20850 United States 12. Was Decedant Evar In U.S. Armed Forcas? 1 ☐ Yas 2 ☑ No if Yas, Giva Yaar or Datas: Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Naver Married 2 Married 1 ☐ Yas 2 ☒ No Specify: Specify 3 ☐ Widowad 4 ☐ Divorcad White 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middla, Maidan Surnama) James Albert Hoffman Bertie Webber 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 201 Upton Street, Rockville, Maryland Kermit B. Mohn/Husband 20b. Place of Disposition (Nama of cematary, crematory or other place) Jan. 17, 1999 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory Alexandria, Virginia Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ayenue Rockville, Maryland 20850-2805 21. Signatura of Funaral Sarvica Licansee M00198 23a. Part. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Intarval Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in death) Trelymone Sequantially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disaase or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of):

Examiner Examiner certificete be executed physician and the buriel-tran Records, P.O. Box 68760, edicai for signed by t t be detech Division of Vital Hospital or Attending Physician: To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: Afte completely filled in by the fun

Physician

/Medical

Examiner

Director

p

Completed

Be

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Maryland

72 hours after

I Hygiena.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important: if item 27 is merked other that any injury or other trauments.

Physician

/Medical

Baltimore, Maryland 21215-0020

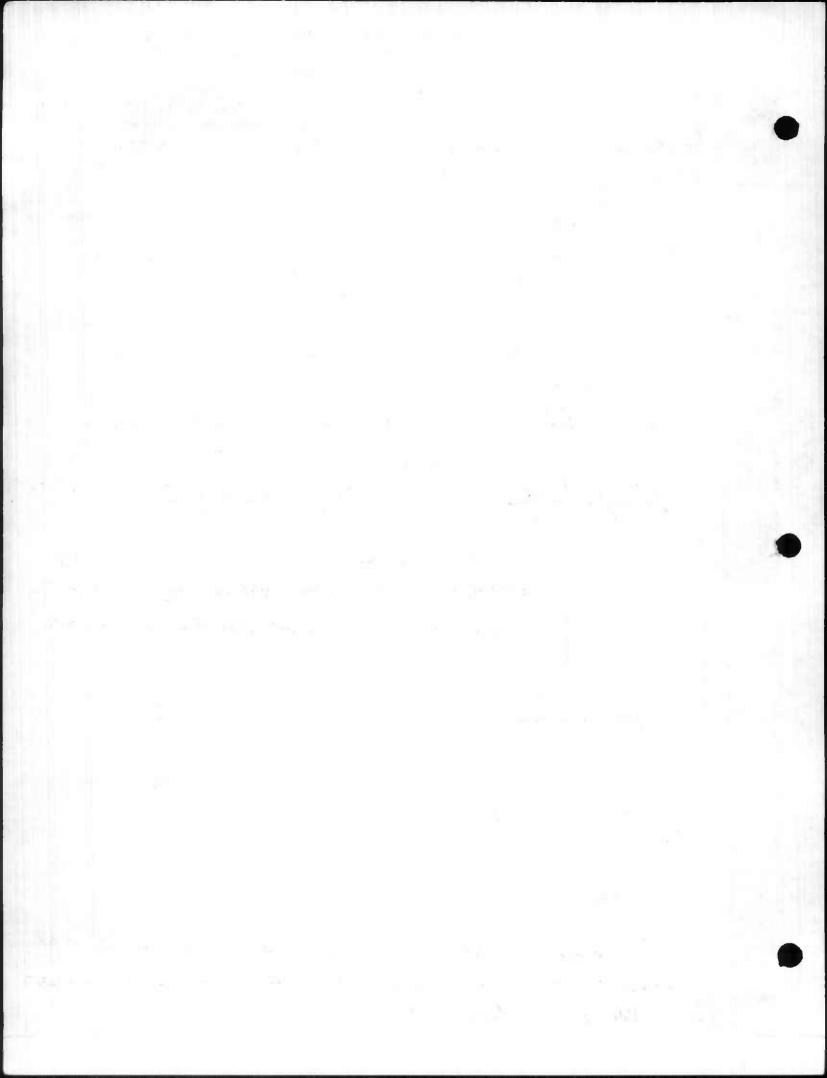
Part II. Other algnificant conditions con		sulting in the underlyin	g causa givan in Part I.	23b. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Unknown
				24a. Was an autopsy parlormed?	24b. Wara autopsy findings available prior to completion of cause of death?
25. Wes case referred to medical			OC Place at Dr	1 □ Yas 2 No	1 ☐ Yas 2 ☐ No
examinar?i /	ospital:	ER/Outpatient 3	Other:	aath <i>(Check only</i> ona) Homa 5 ☐ Rasidanca 8 ☐Ott	ner (Specify)
27. Menner of Death 1 Designation 2 Accident Investigation	28e. Data of Injury (Month, Dey Year)	28b. Tima of Injury M	28c. Injury et Work?	28d. Describe how Injury occur	
3 ☐ Sulcida 6 ☐ Could not be datarmined	28a. Placa of Injury - At h building, atc. (Special	ome, farm, streat, factly)	lory, office	28f. Location (Streat and Number City or Town, Stata)	ber or Rural Routa Number,
29a. Certifiar (Check only one) Certifying Phys	Iclen: To the best of my kno er: On tha basis of axemina and mannar stated.	wiedge, deeth occurrention and/or invastigation	ed at the time, date end place ion, in my opinion, death occ	ee, and dua to tha cause(s) end m curred et the time, data and place,	annar as steted. and due to the cause(s)
29b. Signatura and titla of certifiar	Men	6	29c. Licansa number	29d. Data signa	d (Month, Day, Yaar)

State Registrar

31. Data filad (Month, Day, Yaar) JAN 1 9 1999



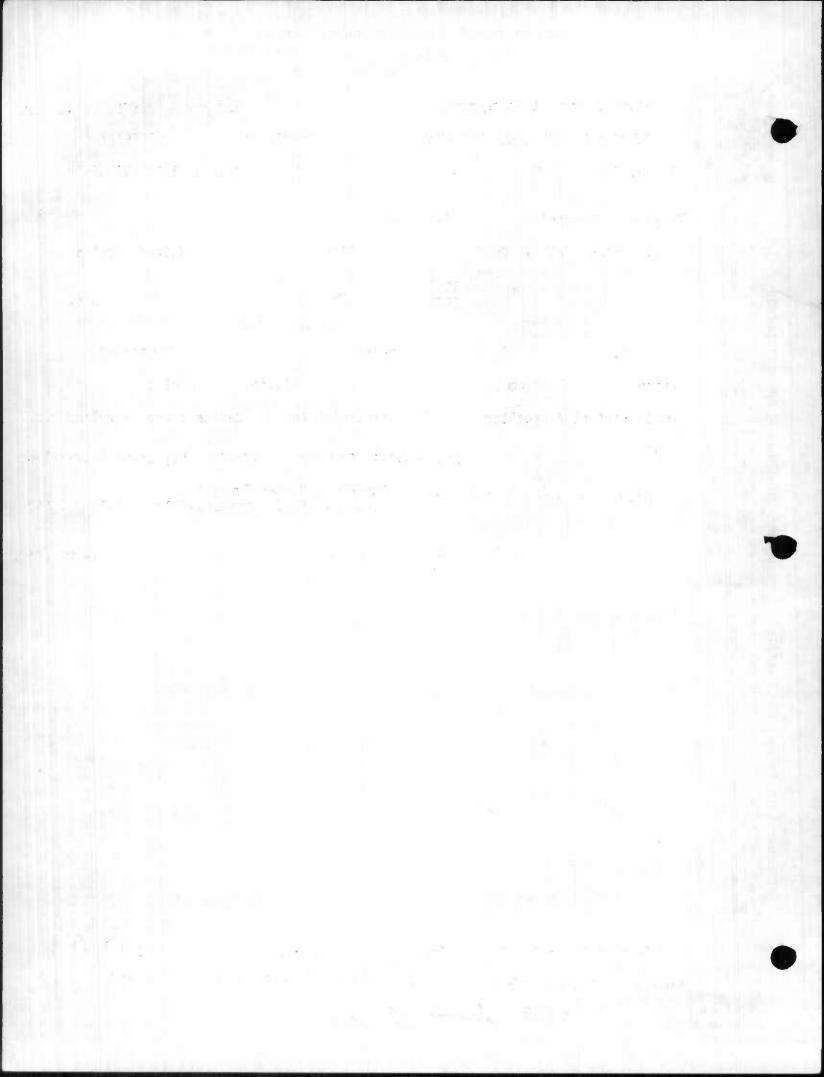
8



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Richard Everett Montgomery January 19, 1999 4:10 P.M. /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5 Social Sacurity Number if Undar 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Oct. 6 1939 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign
 Country) **Funeral** 1 M 2□ F Months Days Houra Min 217-36-7549 59 Yrs Oct. Virginia Director Usual Rasidance of Dacedani with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Med cal Examinar mast be not fed at 1 ☐ Yas 2 No Maryland Frederick Directo New Market 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6901 Green Valley Road 21774 United States deeth Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ⊠Yas 2 □ No 1961 – If Yas, Giva Yaar or Datas: 1967 14. Race - Amarican Indian. 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) permit. Peges 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. I limportant: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercises once. Black, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) (Giva kind of work dona during most of working lifa. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carrier Newspaper 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Everett Montgomery Harless 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Doris Merideth/ Daughter 12 S.Frederick Ave., #4 Gaithersburg, Maryland 20877 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Buriai 2 □ Cramation 3 □ Ramoval from Stata Laytonsville Cemetery 1/22/99 Laytonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licansee 22. Nama and Addrass of Facility Muriel H. Barber Funeral Home P.O. Box 5038 Laytonsville, Maryland 20882 ter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not enter the shock, or haart failure. List only ona ceuse on aach lina. Interval Between Onsat and Death **Shysician** /Medicai Immediata Causa (Final 6 MONTHS nna disaasa or condition resulting in daath) Examiner Examiner attending physician end for use as the buriaf-transit Sequantially list conditions, if any, laading lo immadiata ceuse. Enter Underlying Cause (Diseasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): that the death certificete be exec Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): use as t signed by the a 23b. Did tobacco use contribute to the cause of deeth? Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Nes 2 No 3 Probably 4 Unknown 2 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy performed? Completed page 2 2 NO 1 Type 2 TUNO 1 ☐ Yas certificete or Attending Physician: director. 25. Was cesa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 No 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA After this funeral 28a. Data of Injury (Month, Day Year) 27. Mannagel Daath 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding efter death. 1 ☐ Yas 2 ☐ No invastigation 2 ☐ Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 T Homicida 24 hours Hospital 29a. Cartifian 1 Certifying Physician: To tha best of my knowledga, daath occurred at the time, date and place, end dua to tha causa(s) and manner as atated. Medical To the Hosp within 24 ho To the Fune (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signatura and litla of certifiar 29c. Licansa number January 19, 1999 866 13+1 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) KANAN HUDHUD, MD 801 TOLLHOUSE AVENUE, D3 FREDERICK, MD 21701 31. Data filad (Month, Day, Yaar) 32. Registrar's Signatura State JAN 22 1999 Registrar

DHMH 16 Rev 6/95



20b/Plece of Disposition (Neme of cemetery, cremetory or other placa)

CHRONIC RENAL FAILURE

Pert1: Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line.

GENERALIZED

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

CONCESTIVE HEART FAILURE

28a. Date of Injury (Month, Dey Year)

PERIPHERAL VASCULAR DISEASE

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28b. Time of

ADULT ONSET

CHESED SHEL EMES CEMETERY 1/14/99

DIABETES

22. Name end Address of Fecility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC 1170 ROCKVILLE PIKE, ROCKVILLE MD 20852

ARTERIOSCLEROSIS

26. Place of Death (Check only one)

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month 6:30AM MORRIS JAN 13 1999 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months Deys Hours Min. Dt.C. 12 Year) Birthpleca (State or Foreign Country)
 DC 7. Age (In yrs. lest birthdey) 1₩ 2□F Months Deys 64 DC 10c. City, Town or Location 10d. Inside City Limits 1 ▼Yes 2 No MONTGOMERY ROCKVILLE 10f. Zip Code 10g. Citizen of What Country? 6121 MONTROSE ROAD 20852 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 X) Yes 2 □ No If Yes, Give Yeer or Detes: 1961-63 1 X Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) SALES INSURANCE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) RUTH FELDMAN 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) [COUSIN] 8508 VICTORY LANE, POTOMAC, MD 20854

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or any injury or other traumatic event, the Medical Examples to the traumatic event, the Medical Examples.

Physician

/Medical

Examiner

Funeral

Director

with the Maryland r 28a-f show STANLEY

5. Sociei Security Number

10e. Street and Number

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

SAMUEL MORRIS

LILLIE LEIBMAN

4 Donetion 5 Other (Specify)

W Burial 2 ☐ Cremetion 3 ☐ Removel from State

20e. Method of Disposition

21. Signature of Funeral Serv

mediate Cause (Final lease or condition offing in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

25. Wes case reterred to medical exeminer?

1 Yes 2 No

27. Menner of Deeth

1 Naturel

2 Accident

3 Suicide

10e. State

MD

Directo

Funeral

by

Completed

579-44-1491 Usual Residence of Decedent

10b. County

Physician /Medical Examiner

> Examiner funeral

ed by the a s certificata has b director, page 2 s this

death.

physicien end the burial-transit The law requires that the death certificate be axecuted

Box 68760. Division of Vital Records.

or Attending Physician: Certification: To

Physician/Medical þ Completed Be

To the Hospital or Attendif within 24 hours effer death. To the Funeral Director: At completaly filled in by the fu 6 Could not be determined 4 - Homicide 29e. Certifier 1 - Certifying Physician; To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the cause(s) end manner es steted. edicai 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) and menner stated. (Check only 29b. Signeture end title of certifier

lever

5 Pending investigation

29c. License number 105885

1 Yes 2 No

28c. Injury et Work?

29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

20c. Location - City or Town, Stete

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

MECLITUS

24e. Wes en eutopsy performed?

Other: 4M Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No

28d. Describe how injury occurred

CAPITOL HEIGHTS MD

Approximate Interval Between Onset end Deeth

24b. Were autopsy findings available prior to completion of cause of deeth?

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

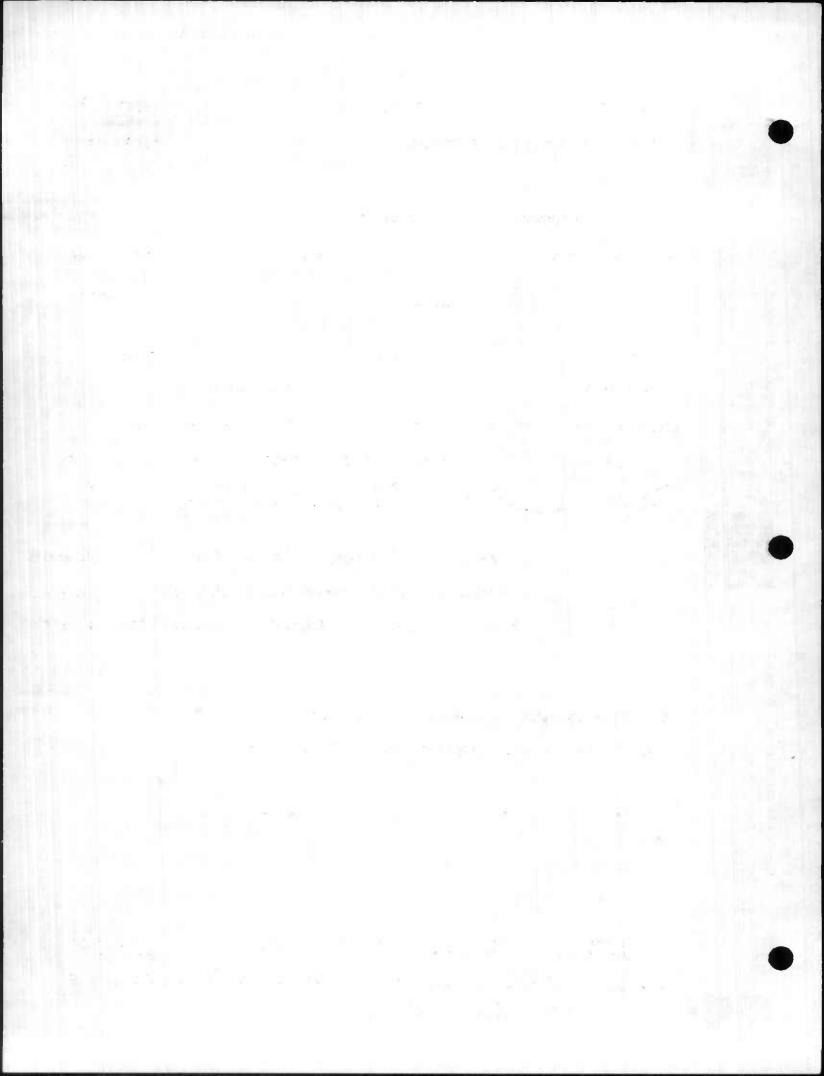
Hospitel:

6121 MONTROSE RD, ROCKUILLE STEVEN LIPSON 31. Dete filed (Month, Dey, Yeer)

Registrar

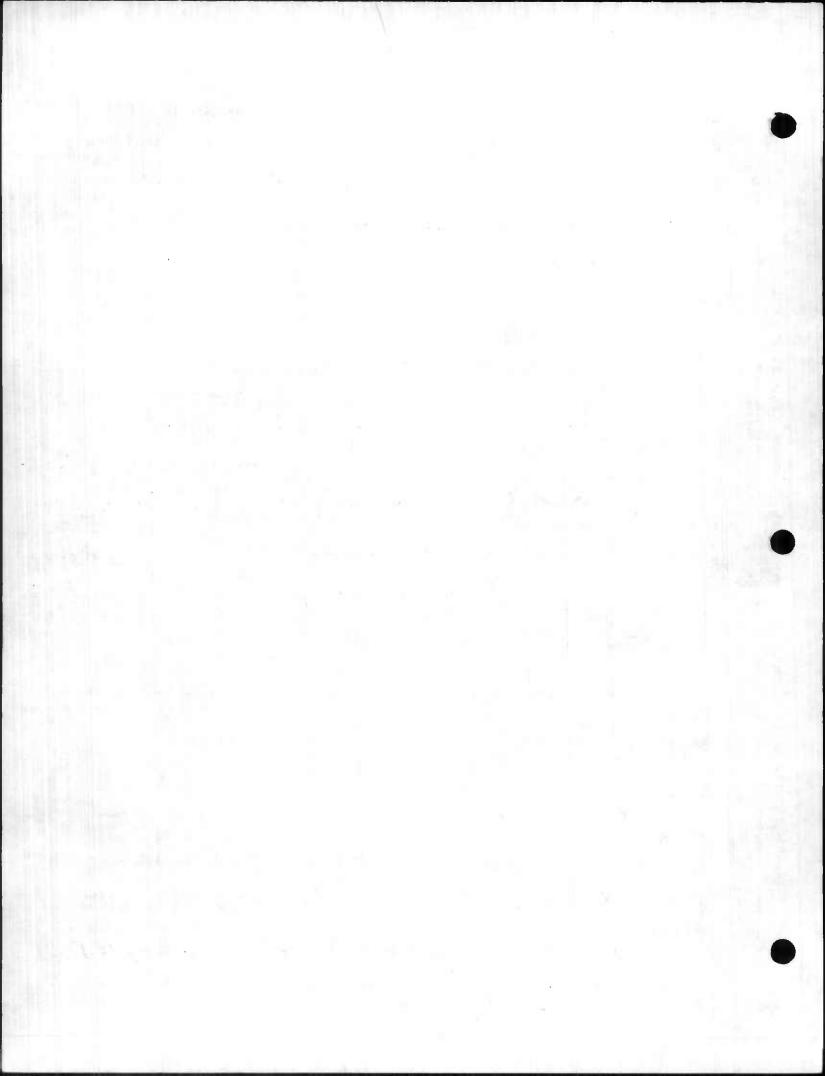
JAN 1 9 1999

32 Registrer's Signeture



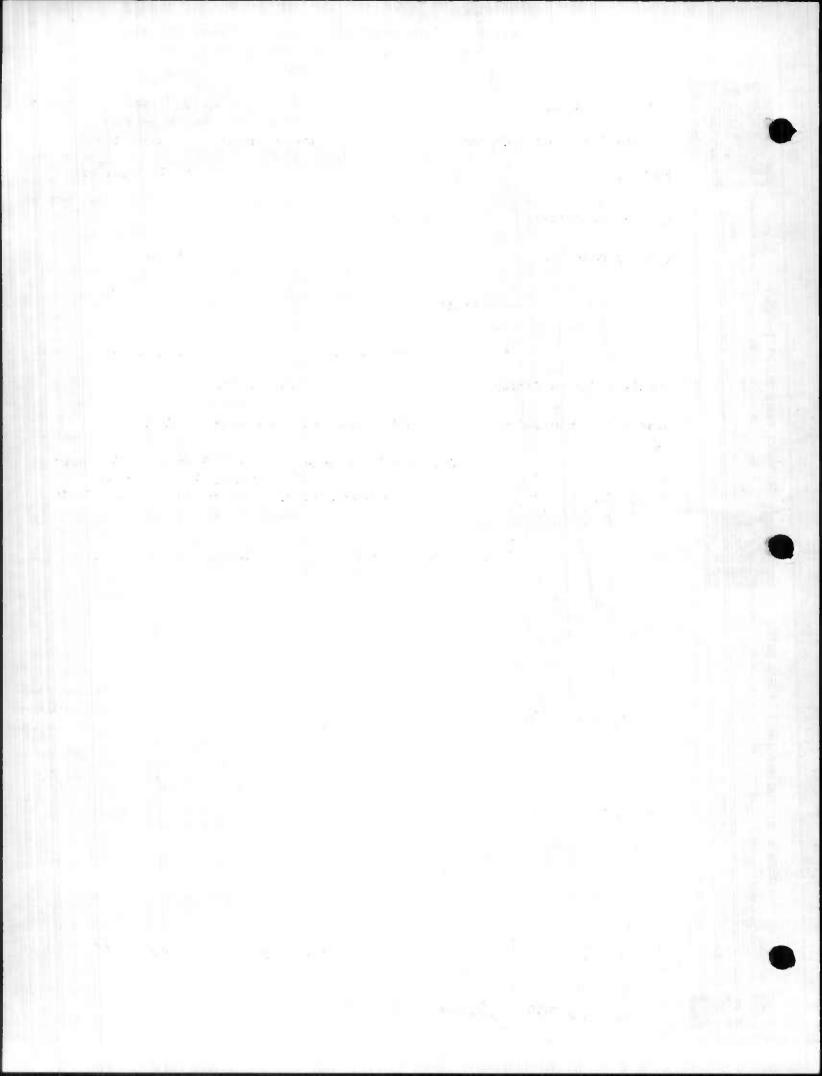
State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 6 1 1

			Ce	ertificate	of Death		Reg. No.	UE	011				
	1. Decedent's Name (First, Middle, Li	nst)				2. Dete of D	Peath		3. Time of Daeth				
Physician	Tomas Wand - W.					Month	y 13	Yeer 1999	7:15 PM				
/Medical	Jorge Mario Mos 4a Facility Name (If not institution, gi				4b City Town	JANUAR n, or Location of Dea			1 12111				
Examiner	The Company of the Co				,		,						
	Holy Cross	Hospital				r Spring		1+90m	ery				
Funeral			rs. last birthday	Months D		Hrs. 8. Dete of B Min. (Month, I	lirth Dev. Year)	9. Birthplece	e (State or Foreign				
Director	N/A	17☑M 2□ F	Yrs.	Michilia D			January 13,1999 Maryland						
70	Usual Residence of Decedent					Januar	y 13,199	y mary	'land				
4 M	10a. State 10b. County	10c.	City, Town or L	ocation				10d.	Inside City Limits				
Aan o	1 1 1												
the Marylar 28e-f ahow notified ector	Maryland Montgome	ry S	ilver S	pring	4		10g. Citizen of What Country?						
or 28e-f a	10e. Street and Number			101. Zip Co	Oe .		Tog. Citizen of V	What Country					
after death with the Manyland or terms 23e or 28e-f show refer man be notified at Funeral Director	10004 Kerwin Roa	d			20901		USA						
	11. Marital Status	12. Wes Decedent Ever in Armed Forces?	n U,S. 13.	Was Decedent	of Hispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	lo- t4. Rac	e - American I ck, White, etc.					
True after	1 ☑ Never Married 2 ☐ Married	1 Yes 2 No				delto riioan, etc.)	A						
by P	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1 Yes 2□	No Specify:		Specify	White					
72 hours after natural; or to a fed by Fu		ducation	16a Dece	edent's Usuel O	ccupation		16b. Kind of Bu		itry				
· c · .	(Specify only highest gr		(Giv		one during most of	of working							
poemit. Peges 1 and 2 should be filed within 1 Department of Health and Mental Hygiers in important: If them 27 is marked other than "rang lajury or other traumatic event, trailed once. To Be Comple	Elementary/Secondary (0-12)	College (1-4or 5+)		_ U . TU T U 30 11									
PEST O			N/A		1 44 44 4 4		N/A	7.					
d 2 should be flie th end Mental Hy 7 is marked oth traumatic event	17. Father's Name (First, Middle, Las	1)			18. Mothers	s Name (First, Midd	e, Meiden Sumen	10)					
To at o	Mario Ovalle				Eva	nelia M	oscoso						
2 should be for a marked of a	19a. Informant's Neme/Relationship	(Type, Print)	19b. Mail	ling Address (S	treet and Number	or Rural Route Num	ber, City or Town,	State, Zip Co	ode)				
and 2 palith n 27 ie	Mario Ovalle	(father)	10004	Vomen	Danii C	41 C		00001					
1 and 1 and 1 And 27 Wher tr	20a. Method of Disposition		b. Place of Disp	Kerwin	of	ilver Spr	20c. Location -	City or Town.	Steta				
2 2 2 2 2	1 ☐ Burial 2 ☐ Cremetion 3 [cemetery, cre	ematory or other	r plece)	1							
DEILIMOTE, bemit. Peges 1 a Department of Her mportant: If Nem ny injury or othe MGS.	4 Donetion 5 Other (Speci	(y) G	ate of	Heaven	Cemetery	1/16/99	Silver_	Spring	Maryland				
Demit. Pego Department. Important: If eny Injury of eng Injury of	4 Donelion 5 Other (Specify) Gate of Heaven Cemetery 1/16/99 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc.												
0 88888	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 209												
	23a Part Falor the disease or con	polications that caused the d	leath Do not or	UU Univ	ersity B	Ivd., W., S	ilver Sp	ring, M	D 20901				
	23a. Pert1. Enter the disease, or con shock or heart failure. List only	one cause on each line.	oaut. Do not of	NOI THO INCOO O	dynig, such as ce	irolac or respirerory	arroat,	Int	tervel Between				
Physician													
/Medical	Immediate Cause (Finel disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): Extreme Orematurity 2 hour												
Examiner	resulting in death)	Due to	o (or as a conse	equence of):									
<u> </u>		Extra	eme p	remat	irity				2 hours				
ordificate be executed ing physician and eas the burial-transit		0.	o (or es a conse		arrig				1710013				
EX ELE	if any, leading to immediate	200 (0 (01 00 0 001100	Addange or).									
death certificate be sweath of for use as the burishmand of for use as the burishman sician/Medical Examples.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C						1					
filcate be physicia as the bur	resulting in death) Last	Due to	o (or es a conse	quence of):				1					
ing ing		d						į					
nat the death cert d by the attendin etsched for use Physician/M		0.		- 51 17									
d de de	Pert II. Other significant conditions	contributing to death but not	resulting in the	underlying caus	e given in Pert I.	23b. DI	d tobacco use co	ntribute to th	ne cause of death?				
the de sched sched						10	Yes 20 No	3 Probab	oly 4 Unknown				
that that deta deta							29/10	3 1 1 0 0 E D	ny 4 diamonii				
0 20 20						040 144	is an Autonou	24h Were	eutopsy findings				
The lew requires to the lew requires to the lew requires to the lew requires to the lew requirements. The lew requirements to							s en eutopsy formed?	svailel	able prior to eletion of cause				
9 9 N D								of dea	ath?				
The lew state has bege 2 s						10	Yes 2 No	1 DY	′es 2□ No				
G Y Cal	25. Was case referred to medical				00.51		/.						
delan: The certificate rector, peg	examiner?	Hospitel: 🛶			Other	of Death (Check only							
Physician: The Physician: The Contilication of the	1 Yes 2 No	1 /2 Inpatient 2	≥ □ ER/Outpatie		4 LI NUIS	ing Home 5 ☐ Re							
ner ther to ne	27. Manner of Death 1 Anatural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time (of 28c.	Injury et Work?	28d. Describ	e how injury occur	red					
att att	2 Accident investigation	on .		М	1 Yes 2 No	0							
or Attending eter death. Director: After d in by the tune ertification	3 Suicide 6 Could not to determined	286. Place of Injury - A	t home, ferm, s	treet, fectory, of	fice	28f. Location	(Street end Numb	per or Rural Re	loute Number,				
tal or Attanding P is after death. al Director: After to ad in by the funers Certification:	4 Nomicoe	building, etc. (Spe	өспу)			City or 1	own, Stete)						
and	29e. Certifier 1 Certifying Pl	hysician: To the best of my i	knowledge des	th occurred at ti	he time date and	place, and due to th	a causa(s) and ma	enner as state	ad				
To the Hospital or Attanding Physician: The is within 24 hours efter death. To the Funesel Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com		miner: On the basis of exam	ination and/or in	nvestigation, in	my opinion, death	occurred at the time	e, date end place,	and due to the	e cause(s)				
tiete e		and manner stated.					204 D : :	d #4	Wasal				
To the trop moon	29b. Signature and title of certifier	11 anne		29c. Li	cense number	0	29d. Date signe	a (Month, Day	y, rear)				
	/ Alan	K. Holdby	ut m	7 1	14536	9	Januar	·v 13.	1999				
	30. Name and address of person who	completed cause of death if	tom 23a) (Type	Print)		•		1	4				
	Alan K. Goldber		1 /-		2000	Silver Spri	in mn	20010					
	31. Date filed (Month, Day, Year)			Gien 1	שטיים כ	JUACI SPLI	J	-0 110					
State	IAN 1 9 19	32. Registrar's Signary	w 19	dos	1.1		-						
Registrar	DAIL TO 10	-	1.	10,000	102								



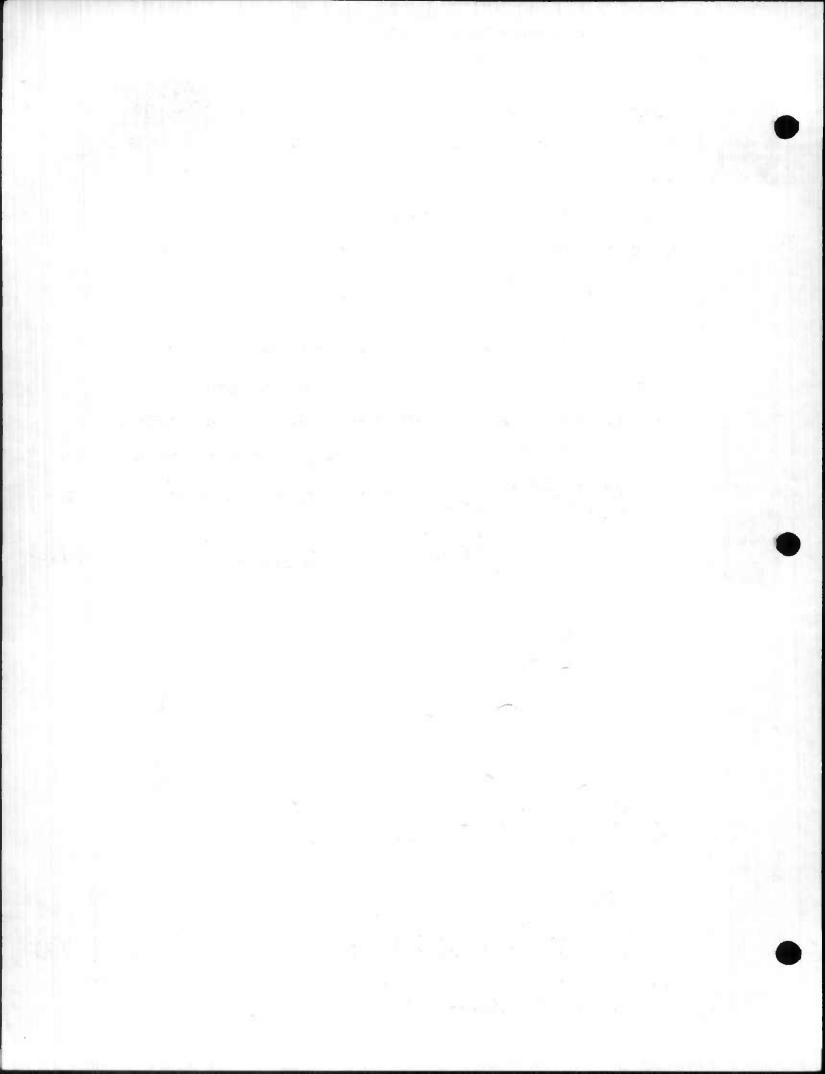
		, maryiana, b	Certificate of	Death	Reg.		_ 0 1 1-	
Physician	1. Decedent's Nama (First, Middle, Last)			1	. Date of Death Month	3. Time of Death		
/Medical	James M. Mundis					1999	12:48AM	
• Examiner	4a Facility Name (If not institution, give street and no			4b. City, Town, or Loca		4c. County of Deat		
	Wilson Health Care Ce		nday) If Under 1 Yaar	Gaithersbu		Montgome		
Funeral Director	5. Social Sacurity Number 356-05-3630 Usual Residence of Decedent	7. Age (In yrs, last birth	rs. Months Days	Hours Min.	Date of Birth (Month, Day, Ye.	1914 Kan	hplaca (State or Foreign untry) 1525	
land land	10a. State 10b. County	10c. City, Town	or Location				10d. Insida City Limits	
Men He ah	Maryland Montgomery	Bethes	da				1X Yas 2□No	
th with the Merylar 23s or 28s-f show ust be notified at rai Director	10e. Street and Number 6601 Lybrook Ct.		10f. Zip Code 2081	7		10g. Citizen of What Country? U.S.A		
020 ours after dea Earth erre	11. Marital Status 12. Was Der Armed 7 1 Never Married 2 Married 1 K Yes, G	eedent Ever in U,S. orces? 2 □ No ive Datas: WWII	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Speci ban, Mexican, Puerto Ri Specify:	ty Yas or No- can, atc.)	rican Indian, e, etc. lite		
5-0 72 hc 72 hc	15. Decedent's Education (Specify only highest grade completed	16a. I	Decedent's Usual Occu	pation during most of working	16b	. Kind of Business/	Industry	
ind 21215-00 be filed within 72 hou tal Hygiene in the resur- ovent, the Medical Be Completed		(1-4or 5+)		a kind of work done during most of working DO NOT use retired) Toward 1				
d 212 filed with hygiene, ther than ont, the	4	J	ournalist	40 10 10 10 10 10 10 10		ournalis	n	
Do fill be fil	17. Fathar's Nama (First, Middla, Last) William Marion Mundis			18. Mother's Name (an Sumama)		
Aarylan 2 should be 1 end Mental 1 is marked or raumatic ev		1.0				Town Olate	Tin Codel	
Maryland to 2 should be file tith end Mental Hy ty 1s marked othe traumatic event. To Be C	19a. Informant's Name/Relationship (Type, Print)			t and Number or Rural I			zip Code)	
e, N 1 and 1 and Health em 27 ther tr	Dolores Mae Mundis-Wife 20a. Method of Disposition	20b. Piace of	Disposition (Name of	Ct., Bethe		Location - City or	Town, Stata	
Baltimore, Maryland 21215-0 permit. Peges 1 and 2 should be filed within 72 h Department of Health end Mental Hygiene. Department of Health end Mental Hygiene important: If flem 27 is merked other than "neture any injury or other traumatic event, the Medical once. To Be Completed	1 Buriai 2 □ Cremation 3	State	seph's Ceme	etery 1/	15/99 Ch	icago, I	llinois	
Balti permit. Departi Importa any inje	21. Signafum of Funeral Service Licensee		22. Nama and Addr 5130 WI A	. 305		er's Son n, D. C.	s 20016	
	23a. Part I find the disease, or complications that shook or hear failure. List only one ceuse on	caused the death. Do no	ot enter the mode of dy	ing, such es cardiac or	espiretory errest,		Approximate Interval Between	
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as ac	Orte	ry Di	seuse	,	Onset and Death Years	
Box 68760, leath certificate be executed attending physician end for use es the buriel-transit	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasuiting in death) Last	Due to (or as a co						
is, P.O. Box es that the death cent igned by the attendin be detached for use by Physician/N	Post II Other classificant and distance acquiring in to	donath house and consulting la	the condent to a course of	iona la Bart I	22h Did tohar	an une annielleute	to the cause of death	
P.O. nat the de d by the a letached Physic	Part II. Other significant conditions contributing to	seath but not resulting in	the underlying ceuse g	wen in Part I.			robably 4 Unknow	
S, Frat s that a med to det	HIZheimer's						, , ,	
/ital Records, P.O. Box clam: The law requires that the death centrificate has been signed by the attendination, page 2 should be detached for use Be Completed by Physician/A					24a. Was an ai	7	Were autopsy tindings available prior to completion of cause of death?	
Re le he ege 2 omp					1 ☐ Yes	_/	1□Yes 20 No	
ital	25. Was case referred to medical			26. Place of Death (Check only one)			
Of Vital Physicien: The Centificate rel director, per centilicate rel director rel	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ER/Out	patient 3 DOA	ther: 4 Nursing Home	5 Residence	6 □Other (Spe	city)	
Division of Vital Records, P.O. Box to the Hospital or Attending Physician: The law requires that the death cert within 24 hours efter defends the certificate has been signed by the attendin completely illied in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/N	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	e of fnjury - At home, fan	jury We 1	Yes 2 No	d. Describe how in	t and Number or Ri	ural Route Number,	
Div Ital or Ital or Ital or Ital or Ital or Cert		ling, etc. (Specify)			City or Town, S			
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 Certifying Physics: To the (Check only 2 Madical Europe On the land mai	e best of my knowledge, pasis of examination and oner steted.	death occurred at the t for investigetion, in my	ime, date and place, an opinion, death occurred	d due to the cause at the time, date	e(s) and manner es and place, and due	s stated. e to the cause(s)	
Nithin Fo the	29b. Signature and title of gratish		29c. Licen	se number	29d.	Date signed (Mont	th, Day, Year)	
20	· cell fredt	2	Do	358/	Ja	nuary 1	12,1990	
(0)	Elliot Godstein	9410 Old	Leorge	town Ro	1. Bet	hesda,	nd. 20819	
State Registrar	31. Date filed (Month, Day, Year) JAN 1 9 1999	Registrar's Signeture	G. Spor	b				

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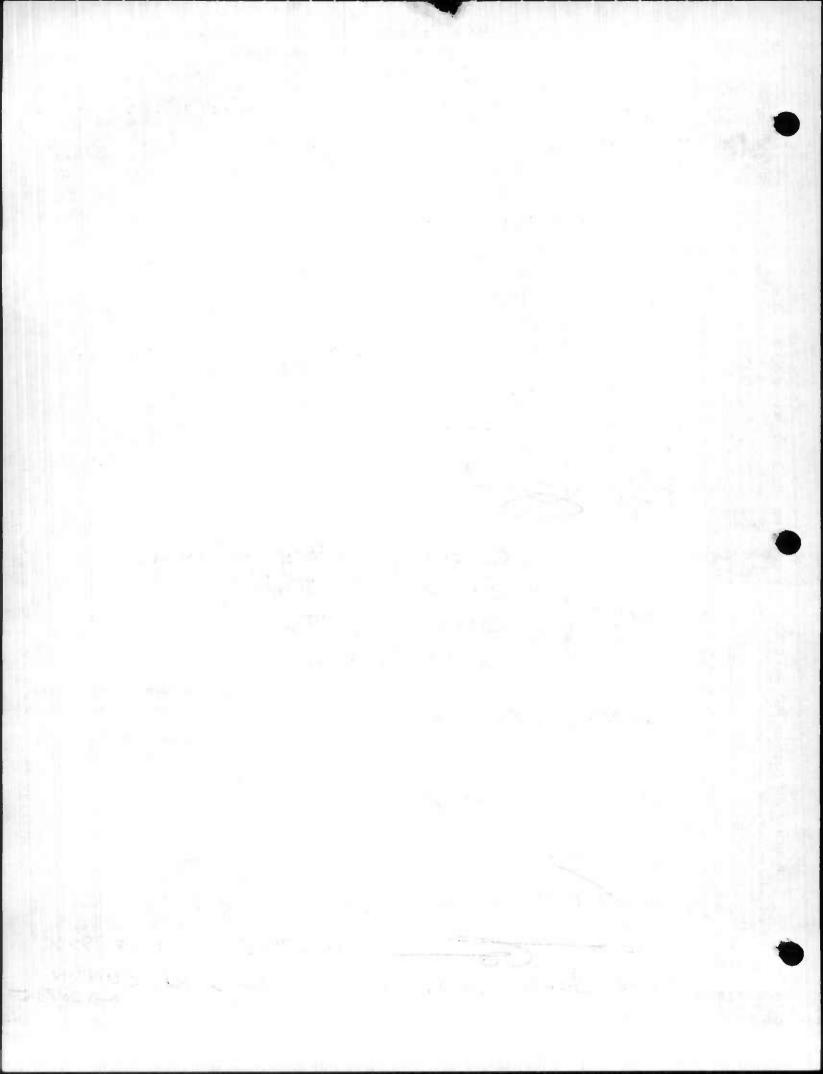
	_		State of Maryl		Certificate of			Reg. No.	02613
Physiciar /Medica	_	Decedent's Name (First, Middle, Last JAMES PETER M	URPHY, Sr.				2. Dete of Dea Month JAN.		3. Time of Deeth 2:45 P.M.
Examine Funeral Director	r	4a. Fecility Name (If not institution, give CARRIAGE HILL BET 5. Sociel Security Number 577-40-0565	HESDA NURSI	yrs. lest birth	E	4b. City, Town, or BETHEST If Under 24 Hrs. Hours Min.)A	4c. County of MONT(
the Maryland 28a-f show notified at	10	Usual Residence of Decedent 10a. State 10b. County MD MONTGOM	100	City, Town					10d. Inside City Limits 1⊠ Yes 2□ No
9 28 2		10e. Street end Number 5300 BOXWOOD COUR	T		10f. Zip Code 208 I	16		10g. Citizen of Wh	et Country?
5-0020 72 hours after death v returns', or items 23s stell Examiner must	à	11. Marital Sfetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever if Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	in U,S.	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☒ No	dispenic Origin? (Sen, Mexicen, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Bleck, Specify:	American Indian, White, etc. WHITE
vithin within the Man	ompiered	15. Decedent's Edu (Specify only highest gred Elementary/Secondary (0-12)	cetion le completed) College (1-4or 5+)		Decedent's Usual Occup Give kind of work done life. DO NOT use retire SICIAN — NE			16b. Kind of Busi	
yland 2 sould be filed Mental Hygi- wrked other with event, if	10 00	17. Father's Name (First, Middle, Last) FRANCIS EUGENE MU				ROMELLI	E COMRI		
C 2 N L		19e. Informant's Name/Reletionship (T) BARBARA F. MURPHY 20a. Method of Disposition	- WIFE	530	Mailing Address (Street O BOXWOOD Consposition (Name of	COURT B		MARYLAN 20c. Location - C	D 20816
Baltimore, semil. Pages 1 ar Department of Hea mportant: If Item my injury or othe asce.		1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funerel Service License	S		RIEL S CEM 22. Name end Addre	ETERY		POTOMAC,	MARYLAND
W Populario	-	23e Part Enter the disease, or computed or heart siture. List only o	icetions full codeed the g	ath. Do no	5130 WI AV	ENUE N.W.	. WASHI	NGTON, D	
Physician /Medical Examiner	ā	Immediate Cause (Final disease or condition resulting In deeth)	. Ve	kir	~	Vises			Onsel end Deeth
6876(difficete be g physicie es the bur	edic	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	o		onsequence of):				
P.O.		Part fi. Other significent conditions con	ntributing to death but not	resulting in t	the underlying ceuse giv	ven in Pert I.	23b. Did t	V	ibute to the cause of death? Probably 4 Unknown
Rec e law has b	nibieren n							en autopsy med?	24b. Were eutopsy findings available prior to completion of cause of death?
of Vital Re Physician: The la this certificate ha ral director, page	0	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient	2□ ER/Outp	patient 3 DOA Oth		ath (Check only or	res 2 No	1 Ves 2 No
Division of To the Hospital or Attending Physwithin 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral director. After this Completely filled in by the funeral director.		27. Manner of Death 1 Natural 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Date of Injury (Month, Day Yea	28b. Tir	ne of 28c. Injur		28d. Describe h	ow injury occurred	
he Hospital of in 24 hours of he Funeral D pletely filled I edical Celegal		29a. Certifier (Check only one) Check sonly one)	sician: To the best of my ner: On the basis of examend manner stated.	knowledge, onlinetion end/	death occurred at the tir for Investigation, in my o	me, date end plece opinion, death occu	, and due to the corred at the time, co	ceuse(s) and manr date end piece, an	ner as ateted. d due to the ceuse(s)
To the complete th		29b. Sonature and title of certifier **Line** 30. Narye and address of person who or	thress	(Hem 23a) (T	29c. Licens	number — 194	18	nuery	Month, Dey, Year) 13/1999,
State		J. BLAINE FITZGER 31. Date filed (Month, Day, Year)	ALD, M. D.	8218	WISCONSIN A	AVE. BET	THESDA,	ID 20814	4-3107

DHMH 16 Ray 6/95



te of Maryland /	Department	of Health and	Mental	Hygiene () (9 1	0
	Cartificate	of Dooth			1 20	1	U

		Decedent's Neme (First, Middle, La	et)		Certificate	of Death	1000000	Reg. No.		
Physic	lan	Shirley		M 1	Jarri .		2. Dete of De Month	Dey	Yeer	3. Time of Deeth
/Medi			L.	Matthe	WS		January			3:45 pm
Exami	ner	4e. Fecility Neme (If not institution, give		r)			, or Location of Deel	h 4c. Count	y of Deeth	
20100		13900 Tower Roa				Brandy	wine	Prin		eorges
, Funeral		5. Sociel Security Number 6. S	6ex 7. A □ M 2√F	ge (In yrs. lest bir	Months [Min. 8. Dete of Bit	24,33	9. Birthpie	oce (Stete or Foreign y)
Director		417-30-0000		65	Yrs.		March	24,33	Washi	ington D
and *		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Tow	or Location				10	d Incido City Limita
aho	5								10	d. Inside City Limits1
5 8 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	ect.	Maryland Prince	George	s Branc						Λ
ath with the Marylan 23s or 28s-f show	ă	10e. Street end Number			10f. Zip Co		П	10g. Citizen of	Whet Countr	y?
ath v	rai	13900 Tower Roa				0613		U.S		
filed within 72 hours efter death with the Maryland Hygiene. ther than "naturel", or items 23a or 28e-1 ahow int, the Medical Examiner must be notified a	by Funeral Directo	11. Maritel Status	12. Was Deceden Armed Forces	?	13. Wes Deceden	t of Hispenic Origir Cuban, Mexican, F	i? (Specify Yes or No Puerto Rican, etc.))- 14. Re	ce - America ck, White, et	
d within 72 hours eft jiene. ir than "naturel", or i	Y	1 Never Married 2 Married	1 ☐ Yes 2√ If Yes, Give	No No	1 ☐ Yes 2€	No Specify:		Specit	V:	
72 hours eft "naturel", or		3 Widowed 4 Divorcad	Yeer or Dates						Blac	: K
nat nat	Completed	15. Decedent's Ed (Specify only highest great	ducation de completed)	16e.	Decedent's Usuel C (Give kind of work of life. DO NOT use if	occupation done during most o	f working	16b. Kind of B	usiness/Indu	ıstry
within	E G	Elementary/Secondery (0-12)	College (1-4or	5+)						
High with Hygiene. Ther ther	ပိ	1 Z 17. Fether's Name (First, Middle, Last,			Secreta	-				vernmen
should be filed withind Mentel Hygiene. marked other than imatic event, the Mentel Men	Be						Neme (First, Middle		ne)	
should be nd Mentel marked o	10	Charles	Davis				en Holme			
le sho le ma le ma raum		19e. informent's Neme/Reletionship (• /				or Rurel Route Numb			
s 1 end 2 should be filled within 72 hr if Heelth end Mentel Hygiene, ttem 27 is marked other than "natur other traumatic event, the Medical		Howard Matthews	Jr/ So				r. Clint			
Pages 1 ent of H nt: If ite		20e. Method of Disposition ★ Buriel 2 ☐ Cremetion 3 ☐	Removei from State	com otor	Disposition (Neme y, cremetory or othe	ot r pleca)	Dete	20c. Location	- City or Tow	m, Stete
permit. Page Depertment o Important: If i eny Injury or once.		4 ☐ Donetion 5 ☐ Other (Specif		Resur	rection	Cem. Ja	an.25,99	Clint	on Ma	rvland
permit. F Depertme Importan eny Injur		21. Signeture of Funeral Service Licer	500			ddress of Fecility				
89 E 2 8		Ilan E	1		1 J			_		
		23a. Part1. Eafer the disease, or comshook, or heert feilure. List only	plications that cause	ed the deeth. Do n	ACAMS Fil	ineral I	Home P.a	. Aquas	co Md	20608 Approximate
Physician	0. 1	shock, of heart feilure. List only	one ceuse on eech	line.				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		nterval Between Onset end Deeth
/Medical		Immediete Ceuse (Final				1 +	-0.10	20-1		
Examiner		diseese or condition resulting in deeth)	e	mona	cy /	triery	900	ease	_	
70 10 10	9			Due to (or es e d	onsequenca of):	41	1		1	
nsit insit	Examiner		b	- Mai	2 Ar	rylun	119		-	
al-tra	Xa	Sequentielly list conditions, if eny, leeding to immediate		Due to (or es e d	onsequenca of):				i	
icete be executed physician end s the bunal-transit		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	c	2rdio	myop	ally			i	
rtificete be executed ng physician end es the bunal-transit	Medicai	resulting in deeth) Lest	,	Due to (or es e c	onsequenca of):				1	
E 00	Me		d k	type	r tous,	on			i	
death cer e attendin ed for use	lan			1						
0 0 0	Physician/	Pert II. Other eignificant conditione or	ontributing to death I	out not resulting in	the underlying caus	e given in Pert I.	23b. Did	tobacco use co	ntribute to t	he cause of death?
requires that the de been signed by the s should be deteched is	Ph	11,00000	Park al	. 10			10	Yee 2 No	3 Proba	bly 4 Unknow
es the	þ	type i cho	Section 6	ma			- 11			
v require been si should	P							en eutopsy med?		e eutopsy findings able prior to
× 50	ple						_	annou i	com	pletion of cause eath?
0 - 5	Completed						10	Yes 2□No		
iclan: The certificate rector, pag		25. Was case referred to medical		^		On Plant		V2	10	Yes 2 No
Physician: this certific ral director,	o Be	examiner?	Hospitei:	ent OFFERIN	nations all no.	Other	Death (Check only o	•	10.00	
Phy or this		27. Menger of Deeth	1 ☐ Inpati	ury 28b. T		4 🗆 Nursi	ng Home 5 Resident	denca 8 □Oth now injury occur		
tending leeth. tor: After the funer	tion	1 Netural 5 ☐ Pending	(Month, De	y Year) In	jury M	tnjury at Work? 1 ☐ Yes 2 ☐ No	200. 1790(109)	10 H Injury GOOD!		
or Attending effer deeth. Director: Affer d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be		iury - At home for	m, street, factory, of		28f Location /	Street end Numb	er or Direct I	Paula Number
in Stage	FT	4 ☐ Homicide determined	building, e	ic. (Specify)	, autodi, raciory, of	1108	City or To	vn, Stete)	er or mural f	noute (vumber,
To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by		29e. Certifier 17 Certifying Phy	tolelon T. II.	-4						
the Hospital hin 24 hours the Funeral hpletely filled	edical	(Check only one)	iner: On the besis of	of examinetion end	deeth occurred et the for investigation, in a	ne time, dete end p my opinion, deeth o	iece, end due to the occurred et the time,	cause(s) end me dete end placa.	onner as stet and due to the	ed. he cause(s)
within 2 To the comple	Med		end menner st	ated.						
5 ½ 5 §		29b. Signature end title of cartifier		_	29c. LI	cense number	20	29d. Date signe	d (Month, De	y, Year)
		lux	(D 27	102	1.	19.1	フフフ
		30. Neme end address of person who d	ompleted cause of	deeth (item 23e) (ype, Print)	. 1		- A		,
		Makesh Cha	udva.	miD	9131	PISCE	factors	Rd	CUI	MOLK
		31. Dete filed (Month, Dey, Year)		er's Signeture	11-17)	ha	N 20725
Sta	te	JAN 2 2 19	199	-eve				,	/0-	1) 24/3-



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Vaar **Physician** 4:55 a.m. Conrad D. McClung 15, 1999 /Medicai Jan. 4a. Fecility Nema (If not Institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Fairhaven Health Care Center Sykesville Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplece (Stata or Foraign Country) **Funeral** Months 1≅M 2□ F 93 Yrs 214 01 1346 Director August 21, 1905 N.C. Usual Rasidanca of Decadent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Machael Examiner count to natural energy once. 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits Md. Carroll Sykesville 1 ☐ Yes 💢 No 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? F 7200 Third Ave. 21784 U.S.A. Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Maxican, Puarto Rican, etc.) 11. Meritei Status 14. Rece - Amarican Indian, Biack, Whita, atc. 1 ☐ Yes 2 ĀNo If Yas, Giva Yeer or Detes: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White þ 3 XWidowed 4 ☐ Divorcad Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grede complated) 16b. Kind of Businass/Industry Eiemantary/Sacondery (0-12) Coilega (1-4or 5+) Manager Hutzlers Dept. Store 17. Father's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Charles Hugh McClug 2 Margaret V. Zink 19a. Informant's Neme/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Nancy Griffith (daughter) 5 Sugar Tree Place Cockeysville, Md 21030 ca of Disposition (Name of Data 20c. Location - City or Town, Stata 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20e. Method of Disposition 1 ☐ Buriat 2 X Cramation 3 ☐ Ramovei from Stata Carroll Cremation Service 1/15/99 Hampstead, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Sykesville, Md. 21784 21. Signeture of Funerai Sarvica Licansee Haight Funeral Home & Chapel
23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only or cause on each line. P.O.Box 195 Approximate Interval Between Onset and Death Physician Immediate Causa (Final disaasa or condition rasulting In daath) /Medical . Chronic obstructive pelmonary disease 10 years Examiner Dua to (or es e consequança of): physician and s the burial-transit Sequantially list conditions, if any, leading to immadiate causa. Enter Undarlying Causa (Disaesa or Injury that initiotad evants rasulting In daeth) Last Dua to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or es a consequance of): USB as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the s 23b. Did tobacco use contribute to the cause of death? Yaa 2 No 3 Probably 4 Unknown fibrillation à 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Congestive heart feinlure pege 2 s certificate 1 Yes 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certifica funeral director, 25. Was case rafarred to medical examinar?

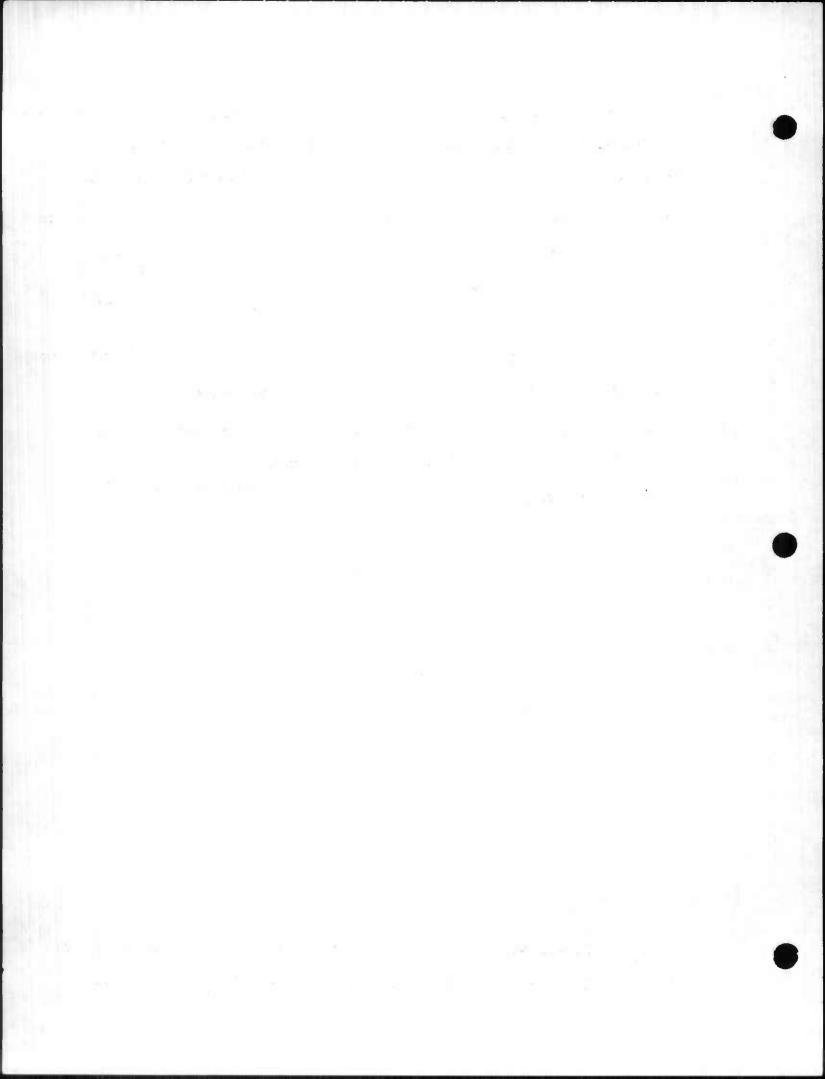
1 Yes 2 No 28. Placa of Death (Check only ona) Hospital: Other: Danursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Panding invastigetion 1 Neturel 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be detarmined 28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled TS Certifying Physician: To the best of my knowledge, daath occurred at the time, deta and placa, and dua to tha causa(s) end manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Cartifian Medical 29b. Signeture end titla of continu 29c. Licansa number 29d. Data signad (Month, Day, Year) 15, 1999 January D34849 30. Name and addrass of person who complated causa of daeth (Itam 23a) (Type, Print) Road Eldersburg MD 21784 1645 Liberty William Tan, MD 31. Date filed (Month, Day, Year)

State Registrar

JAN 1 9 1999

32. Ragistrer's Signatura



State of Maryland / Department of Health and Mental Hygiene

ily Mulicii		2000	Ce	rtificate of	Death	R	eg. No.	UZO) 0	
	1. Decedent's Name (First, Middle, La	est)				2. Date of Dea Month	th	Year 3.1	Time of Death	
Physician /Medical	Katherine Lynn	Sheldon Mu	nch			January			0:32 P.M.	
Examiner	4a Facility Name (If not institution, given				4b. City, Town, or	Location of Death	4c. County o	of Death		
	Chesapeake City	ake City	Cec.	il						
Funeral		DA OTT	. last birthday)	Months Days			Year)	9. Birthplace (Country)	(State or Foreign	
Director	218-80-3368	38	Yrs.			August	20, 1960) Wilmi	ington, D	
1	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. In	nside City Limits	
s or 28a-f show be notified at Director	Maryland Ceci	1		Ear	leville			11	☐ Yes 2万No	
be notified Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?		
II D	28 Beach View Av	enue		219	19		-	d State	es	
ioer must	11. Marital Stetus	12. Was Decedent Ever in I	U,S. 13.	Was Decedent of I	Hispanic Origin? (S pan, Mexican, Puerl	pecify Yes or No-		- American Inc	dian,	
		Armed Forces?				o Hican, etc.)		c, white, etc. Whit∈		
Ď		If Yes, Give Yeer or Dates:		1 ☐ Yes ACXNo	Зреспу :		Specify:	WIIILLE	3	
Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occu	pation during most of wor	rkina	16b. Kind of Bus	siness/Industry	1	
nple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wor		Anima	1 Care/	/SPCA	
S	12		Ani	mal Atte	1					
a B	17. Fether's Name (First, Middle, Last					ne (First, Middle, I	Maiden Sumame	")		
0						y Price				
	19a. Informant's Name/Relationship (t and Number or Ru				θ)	
	Robin L. Duff/Si				, Earlevi		-			
	20a. Method of Disposition XIX Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	osition (Name of matory or other pla	ice)	Date	20c. Location - C	iny or rown, S	state	
1	4 Donation 5 Other (Special	- DL			y/January	19, 199	9 Earley	ville,	MD	
Depart Import any in ansa	21. Signature of Fundral Service Light	1500	Fe	2. Name and Address Ho	ess of Facility elfenbein	& Newna	m Funera	al Home	P.A.	
	1 2/m 3/	Condlos	22	6 F Main	n Street	Cecilto	n Mary			
	23a. Part1. Enter the disease, or com shock, or feart failure. List only	plications the caused the dea on cause in each line.	ith. Do not en	ter the mode of dyi	ing, such as cardia	or respiratory arr	est,	Appr	roximate rval Between	
ian								Onse	set and Death	
cal ner	Immediate Cause (Final disease or condition resulting in death)	· Multin	ole	injurie	5			i i		
	resulting in death)		or as a conse					-		
Examiner		b						i		
Хап	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Due to (or as a conse	quence of):						
8	cause. Enter Underlying Ceuse (Disease or injury that Initiated events	c								
edical	resulting in death) Last	Due to (or as a consec	quence of):				1		
should be detached for use as the burial-transit leted by Physician/Medical Examir		d								
	Part II. Other significant conditions of	antributing to dooth but not re	nulting in the c	andark inn an una ni	iven in Read I	22h Did to	hacaa .uaa aaa	tribute to the	cause of death?	
PhysicianM	Partin. Other aigniticant conditions of	contributing to death but not re	sulling in the t	moenying cause gr	wen in Fent I.				4 □ Unknown	
by P						,,,,	es 20 110	V_ From Sty	4 Onkalowii	
3 2						24a. Was a		24b. Were at	utopsy findings	
ete						perfor	med?	complet of death	le prior to tion of cause h?	
Completed						110/0	es 2 No		8 2□ No	
e Com	25. Was case referred to medical				20 Di(D	- 1		1 M 100	3 2LJ NO	
0	examiner?	Hospital:	75000	Ot Doc Ot	A	eth (Check only or		. 10		
E	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o	-		tome 5 ☐ Reside			scene_	
tion	1 Natural 5 Pending	(Month, Day Year)	Injury 23		ork?]Yes 2,2%[No				4	
fica	3 ☐ Suicide 6 ☐ Could not b	e 200 Place of laiver At I				Autom 281. Location (S	reet and Numbe	accide or or Rural Rou	ute Number Bridge	
Certification:	4 Homicide determined	building, etc. (Spec	ily)							
U E	29a. Certifier 1 Certifying Ph	ysicien: To the best of my kn	Stre	h occurred at the ti	ime, date end place	and due to the c	County, ause(s) and mar	nner as stated.		
edical	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) Check only one									
Medical Certification: To Be (29b. Signatura and title of certifier			29c. Licen	se number	2	9d. Date signed	(Month, Day,	Year)	
	1 1 111	O.C.M.E.		Januar	y 14, 1	1999				
	30. Name and address of person who	completed cause of death (to	m 23e) (Type	Print)						
		3 1			reet, Bal	ltimore	Marrolan	d 2120	1	
State	31. Date filed (Month, Dey, Year)	32. Registrar's Sign	eture /	1		chiore,	THITYTOUR	u 21201	-	
egistrar	31. Date filed (Month, Dey, Year) JAN 19 19	99 Jenera	Ø.	spork.						
			-							

DHMH 16 Rsv 6/95

RRE DIL MAD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month DARBARA SPELLMAN MOORE 1.00 Am 01 4a. Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death MAGNOLIA HALL NURSING CENTER KENT CHESTERTOWN If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6 Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 10 M 20F Months 156-14-4153 92 Yrs. 02-17-1906 CONNECTICUT Usual Rasidance of Decedant 10a. Stata 10h County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No KENT CHESTERTOWN 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? WASHINGTON YARK 21620 U.SA 12. Was Decedant Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Dates: 11. Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1□ Yas 2□No Specify: Specify: AMERICAN INDIAN 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 18b. Kind of Business/Industry (Specify only highast grade completed) Elementery/Secondery (0-12) Collega (1-4or 5+) NURSING HOME NURSE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) THOERE SPELLMAN GEORGE & Markson 19a. informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Coda) MRS. VALERIE WILLIAMS. SOCIAL WORKER 302 MAIN ST. CHURCH HILL. MD 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Date 1 Buriai 2 Cramation 3 Ramoval from Stata 1 21 ASBURY CEMETERY CHESTERTOWN, MD 4 ☐ Donation 5 ☐ Othar (Specify) of Funaral Sarvice Licensae 22. Nama and Addrass of Facility WALLEY FUMERAL HOME. CHESTERTOWN MO 21620 Jalley 23a Part. Entar the disease, or complications that caused as death. Do not anter the mode of dying, such as cerdiac or respiretory arrest, pock, or heart failure. List only one ceuse on each line. Approximate Intarval Batween Onsat and Death Severy Immediata Causa (Final disease or condition resulting in deeth) Years Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceusa (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequance of): Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23h. Did tohecco use contribute to the cause of death? Unknown 1 Tes 2 No 3 Probably 24e. Was an autopsy performed? 24b. Were eutopsy findings available prior to complation of cause of daath? 1 ☐ Yas 2 ☐ No 26. Placa of Deeth (Check only ona) Other: Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

that the death certificete be executed

P.O. Box 68760,

Records,

Division of Vital

The law requires

certificate

Physician

/Medical

Examiner

Director

by

Completed

21. Sig

Funeral

Director

r is marked other than "naturel", or items 23a or 28a-f ahow traumatic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or then any injury or other traumatic event, the Medical Evantues once.

Baltimore, Maryland 21215-0020

death

Examiner physician end s the burial-transit Physician/Medicai ettending | been signed to should be det p Be Completed ate has To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 2 Medical Certification:

25. Was cese referred to medical exeminar? 1 Yas 2 No

27. Menner of Death Natural Accident

3 ☐ Suicida 4 Homicide

29a. Certifian

5 Panding Invastigation 6 Could not be datamined

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28b. Tima of

1 ☐ Yes 2 ☐ No

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

28d. Dascribe how injury occurred

29b. Signatur and titla of certifier

JAN 19 1999

28a. Date of Injury (Month, Day Yaer)

29c. Licansa number

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

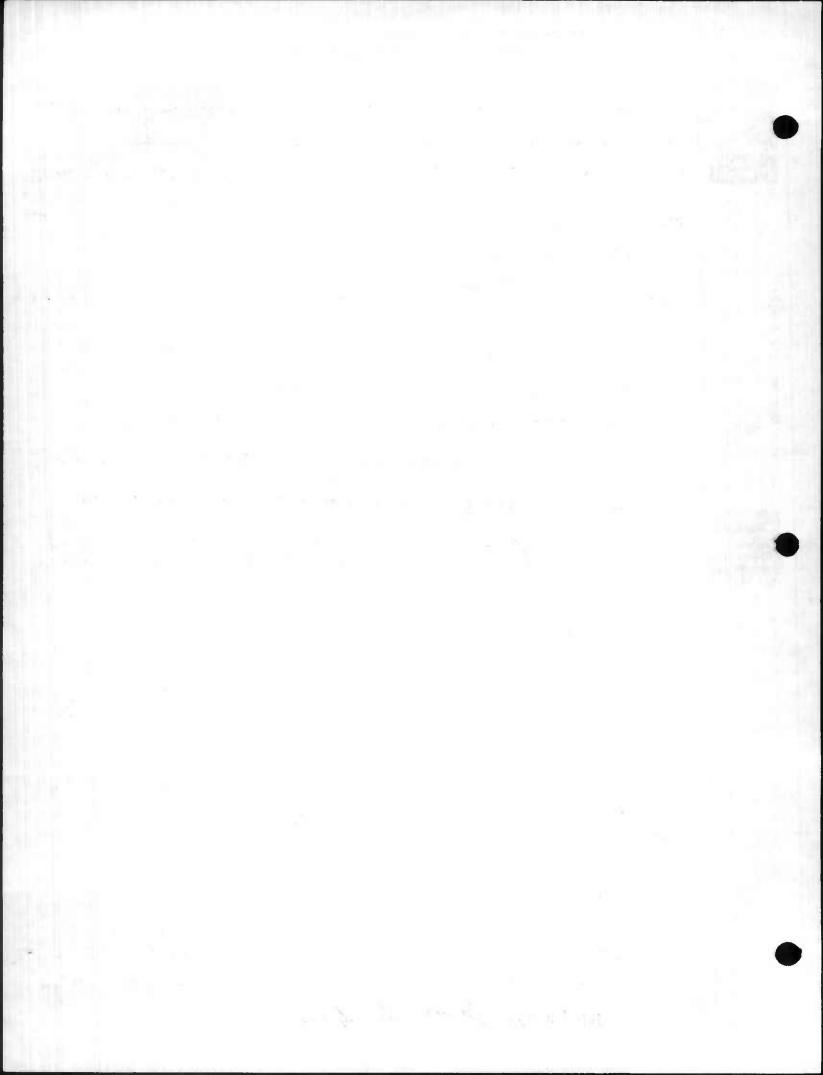
2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29d. Data/signed (Month, Day, Year)

30. Nama end addrass of person who complated crusa of death (itam 23a) (Type, Print)

Dr. WAYNE BENJAMIN. 6602 CHURCH HILL RO. CHESTERTOUN, MD 21620 31. Data filad (Month, Dey, Yaar) 32. Ragistrar's Signatura

State Registrar



CATILIENCE 6 Meigel

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State of Maryland / Department of Health and Mental Hygiene 9 26 | 8

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month CATHERINE GERTRUDE MEIGEL January 15, 1999 11:15 AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** WATERVIEW HEALTHCARE CENTER SALISBURY WICOMICO 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 5. Sociei Security Number 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□ M 2₩ F Deys Hours Yrs. 210-36-7691 96 Director January 24,1902 Pennsylvania Usuel Residence of Decedent 10e. Stete 10b County 10c. City, Town or Location rai', or Items 23a or 28a-f show Examiner count be notified at 10d. Inside City Limits 1 ☐ Yes 2√ No Director Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1503 Magnolia Drive 21801 USA deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed the Midlical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry lith end Mental Hygiena. 27 is markad other than "r r traumatic event, me Wes Elementary/Secondery (0-12) College (1-4or 5+) Domestic 8 Housewife 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pegas 1 and 2 should be 1 Tent of Health end Mental Mary Madden Melchior Oskamp 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pegas 1 and 2 s Department of Health er Important: If itsm 27 is any injury or other trau Robert Meigel/Son 1503 Magnolia Dr., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/21/99 Sharpsburg, PA ST. Mary's Cemetery 21. Signeture of Funeral Service Lice 22. Name end Address of Facility Holloway Funeral Home Professional Association CFSP 501 Snow Hill Rd., SAlisbury, MD 21804 23a. Pert1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart fellure. List only one cause on each line. **Physician** Dreu Morit 9 DAYS /Medical Immediete Ceuse (Finel diseese or condition resulting in death) Examiner Physician/Medical Examiner sician and burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequença of): P.O. Box 68760, Due to (or es e consequença of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Subdund demons 1 Yes 2 No 3 Probably 4 Unknown Be Completed by Records, 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No of Vital or Attending Physician: 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To filled in by the funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division 1 Naturel 5 Pending Investigation Hospital or Attendin
 124 hours after death.
 Funeral Director: Att 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end manner stated. Medicai 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 29b. Signeture and fille of certifier 29c. License number 39813 1/15/99 wello mo 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

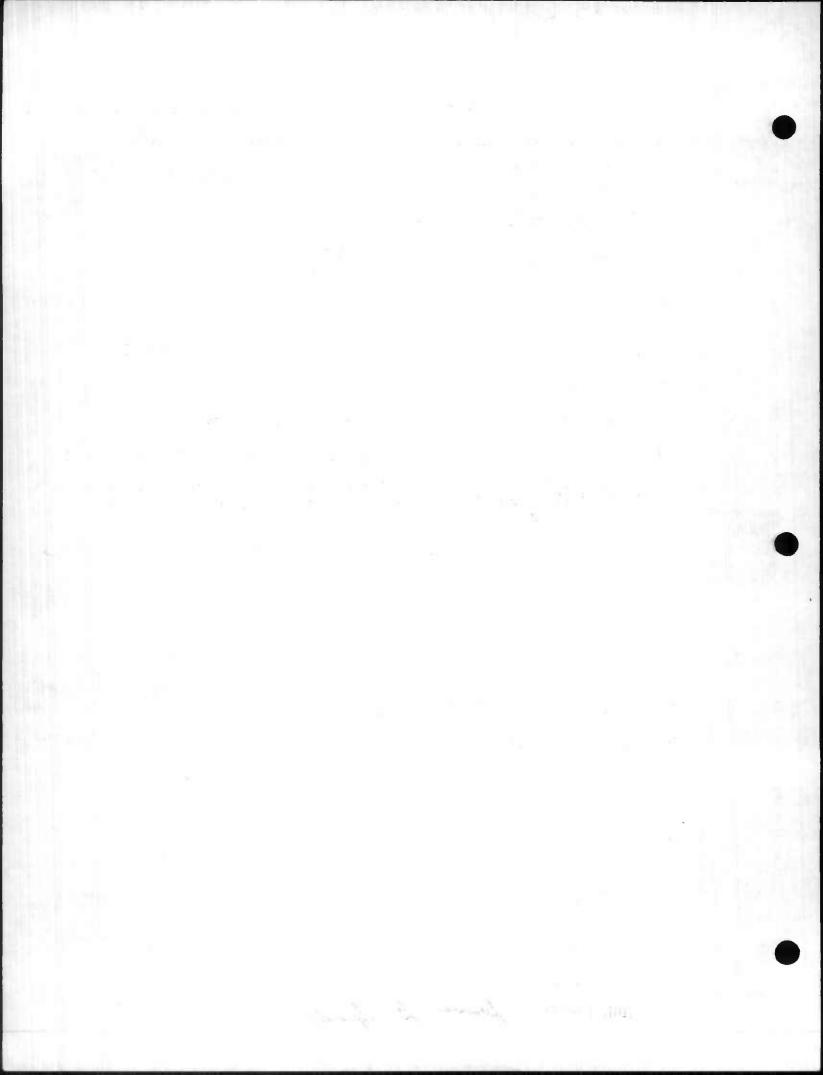
AN ANINS 1104 West Charles of Dead Thomas, Stoles are 21804 9

State Registrar 31. Dete filed (Month, Day, Year)

JAN 1 9 1999

32. Registrar's Signeture

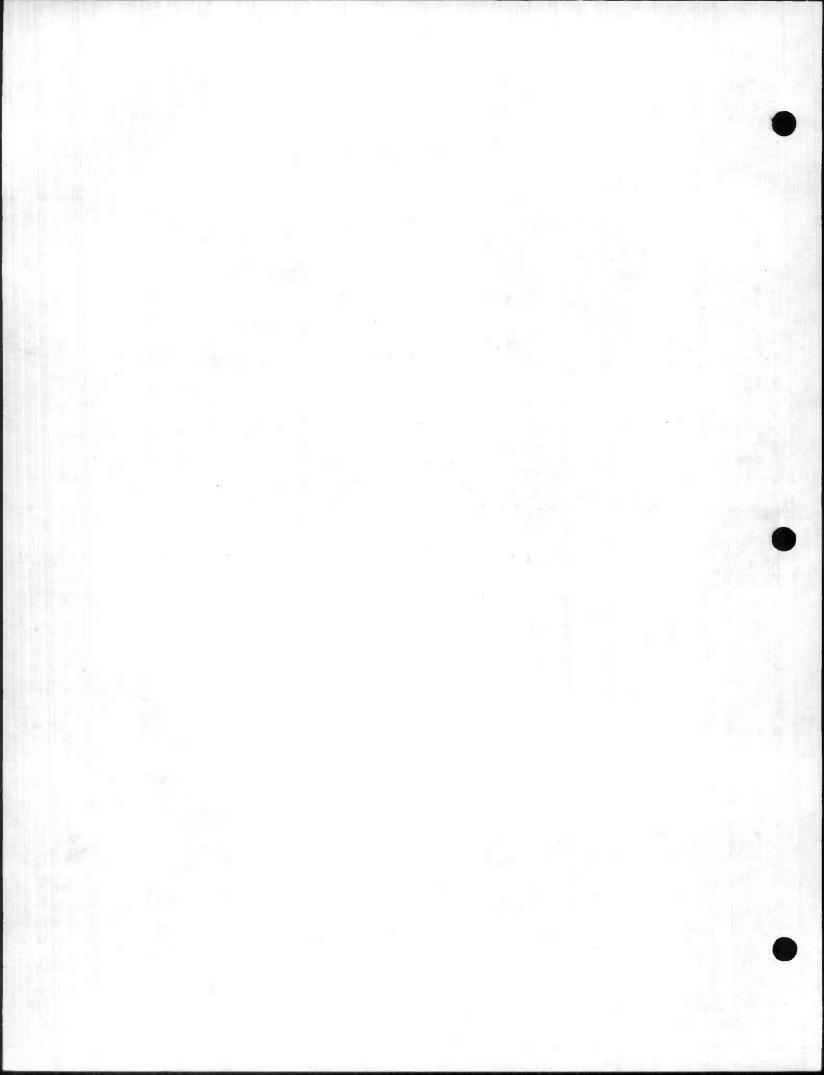
& Sports



State of Maryland / Department of Health and Mental Hygiene 9 0 2 6 1 9

	Certificate of Death	R	eg. No.	32013									
	Decedent's Neme (First, Middle, Last)	2. Data of Deat		3. Tima of Death									
sician edical	Son Thi Nguyen	January	18, 1999	7:30 AM									
aminer	4a Facility Neme (If not institution, give street and number) 4b. City, Town	n, or Location of Death	4c. County of Dea	ath									
		na Park	Montgor	nery									
eral tor	115-70-6908 81 Yrs.	Min (Month Day	Year) 9. Bii	rthplaca (Stata or Foraign ountry) tnam									
	Usual Residence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits									
5				1 ☐ Yes 2 🖾 No									
octo	MD Montgomery Silver Spring												
ral Director	10e. Street and Number 10f. Zip Code 20903		Og. Citizen of What C										
by Funeral	11. Meritel Stetus 1 Never Merriad 2 Married 1 Never Merriad 2 Married 3 X Widowed 4 Divorced 12. Wes Dacedant Ever in U,S. Armed Forcas? 1 Yas, 2 No If Yas, Sive Yaar or Datas: 13. Was Decedent of Hispanic Origin If Yas, specify Cuban, Mexican, Forcas If Yas, specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am. Black, Whi Specify:										
Completed	15. Decedant's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Giva kind of work done during most o	f working	16b. Kind of Businass	s/Industry									
ple	(Specify only highest grade completed) (Giva kind of work done during most of life. DO NOT use retired) Elementary/Secondery (0-12) Collega (1-4or 5+)	Working											
No.	9 Homemaker		Own Ho	ome									
Be	17. Fether's Nama (First, Middla, Last) 18. Mother's	Nama (First, Middle, I	<i>Maiden Suma</i> ma)										
To	Duoc Van Nguyen Duy	Duyen Thi Nguyen											
	19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number of	nd Number or Rural Route Number, City or Town, Stata, Zip Code)											
	Thanh Nguyen (son) 8321 Tahona Drive, S	Silver Spri	ng. MD 20	903									
eg .	20a Mathod of Disposition 20b. Place of Disposition (Nama of		20c. Location - City or										
any injury or other traumatic event, the Med and injury or other traumatic event, the Med and injury or other traumatic event, the Med To Be Comple	1 Burial 2 X Cramation 3 Removel from Stata cematary, crematory or other place)	1/20/00	1/20/99 Alexandria, Virginia										
	4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility												
	Home, Inc. 500 U Silver SPring, MD	niversity	Blvd. West	runerar									
cian lical liner	3a. Pert1. Entar tha disease, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Two Days Due to (or as a consequence of):												
	Sequentially list conditions, Due to (or as e consequence of):												
edical	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disaase or injury that initiated events resulting in death) Last Dua to (or as e consequence of): Dua to (or as e consequence of): TEN 16 Dua to (or as a consequence of):												
lan/M	d												
detached for use	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of de											
y Phy		t 🗆 Y	ea 2 No 3□1	Probably 4 Unknown									
, page 2 should be detached for use Completed by Physician/I		24a. Wes a perform		. Were autopsy findings available prior to completion of cause of death?									
Com		1 🗆 Y	es 2000	t ☐ Yas 2 ☐ No									
Be	25. Wes case referred to medical 26. Place of	Deeth (Check only or	18)										
0	axaminar? Hospitel: Other:	ing Home 5 🗆 Reside		ecify)									
	27. Mannar of Deeth 28a. Data of Injury 28b. Tima of 28c. Injury at	1	ow injury occurred	00.17)									
to the	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accidant Invastigation M 1 Year 2 No.												
completely filled in by the funeral Medical Certification: 1	3 Suicide 4 Homicide 6 Could not be datarmined 28a. Placa of Injury - At home, ferm, street, factory, office building, atc. (Specify)	28f. Location (Si City or Town	treet and Number or F n, Stete)	Rural Route Number,									
pletely fill edical	29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and process of my knowledga, data at the tima, data and process of my knowledga, data at the tima at the tima, data and process of my knowledga, data at the tima at the tima, data and process of my knowledga, data at the tima at the tima, data and process of my knowledga, data at the tima at the tima, data and process of my knowledga, data at the tima at the tima, data at the tima at th												
Me	296. Signature and title of certifier Surem D 2.689		29d. Data signed (Mor	18, 1999									
	30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) Dang C. Bui, MD 400 University Blvd. East, Silve	r Spring	MD 20901										
Chal	31. Data filed (Month, Day, Year) 32. Registrar's Signatura	r phring,	. Z0701										
State	JAN 1 9 1999												

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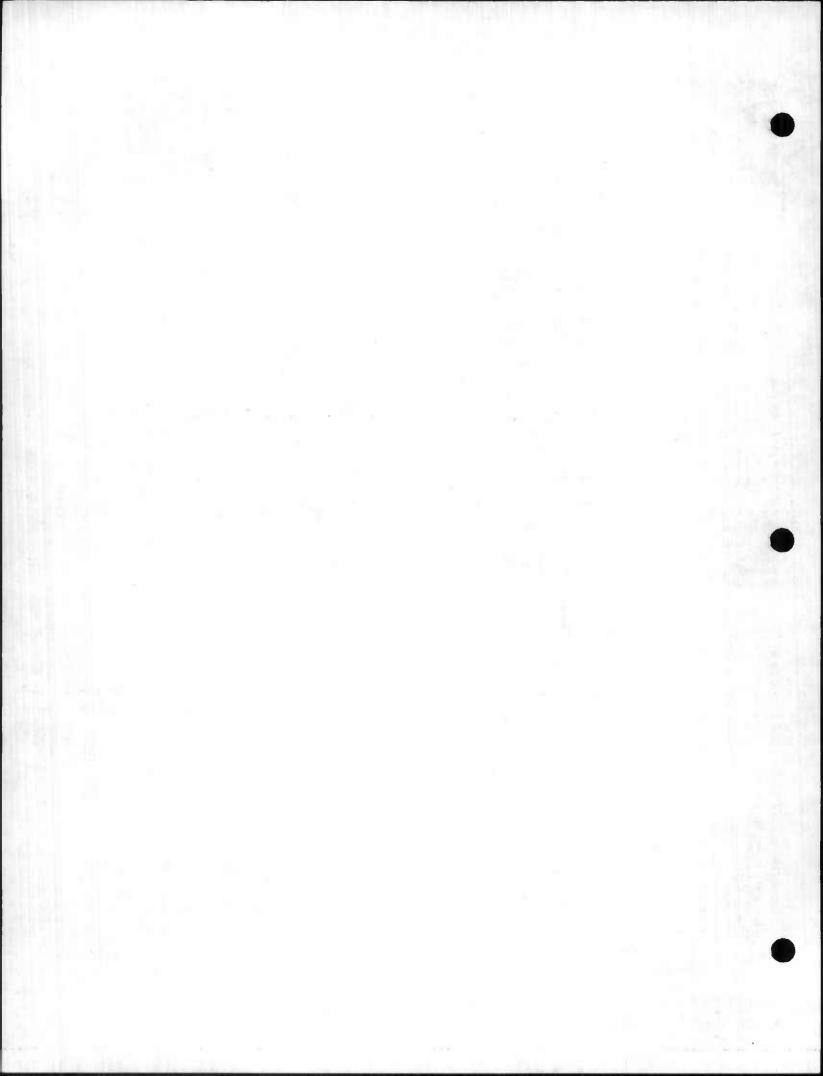
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Fleecie Taylor Noves Month Day **Physician** Jan. 15 21:45 /Medical 4b. City, Town, or Location of Death 4c. County of Death Carroll 4a Facility Name (If not institution, give street and number) Examiner Westminster Carroll County General Hospital 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign NC Ountry) 5. Sociel Security Number 242–22–6297 Months Days 8. Date of Birth (Month, Day, Year) March 29 1927 **Funeral** Hours 10 M 20 F Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show Marriottsville Carroll 1 Yes 2 No Director 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21104 b 2000 Arrington Road Herra 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bieck, Whita, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? i Hygiene. other than "natural", or item 1 Yes 2 WNo
If Yes, Give
Year or Dates: 1 Navar Married 2 Married 21215-0020 Specify: White 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Collega (1-4or 5+) health care permit. Pages 1 and 2 should be filled w.
Department of Health and Mental Hygiens, important: if fleen 27 is marked other that any Injury or other traumatic eacher that 9000. LPN 18. Mother's Name (First, Middle, Maiden Sumeme) Bertie Cornett Baltimore, Maryland 17. Fathar's Name (First, Middle, Last)
Edward W. Taylor 86 19a. Informent's Name/Relationship (Type, Print)

James Benjamin Noyes (spouse) 19b Mailing Address (Street and Number or Rural, Route Number City or Town State Zip Code) 2000 Arrington Rd. Marriotsville Md 21104 20a. Method of Disposition 20b. Piece of Disposition (Name of 20c. Location - City or Town, Stata Dete 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 1-19-99 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signeture of Funerel Service Licenses D rease Nau P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate tntervat Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Pneumonia 2 weeks Examiner Due to (or as a consequenca of): Examine The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician as the burial-Box 68760. Physician/Medical Due to (or es e consequenca of) P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic obstructive Pulmonary disease signed to det Division of Vital Records. Àq 24b. Ware autopsy findings available prior to Completed 24a. Was en autopsy performed? small cell cancer of Lung completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: 1 (\$) Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 ☐ Homicide 24 hours a Medical 29a. Certifier 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated. within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and manner steled. 4 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number m.D. January, 15, 1999 D0052479 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) LISA Kim, m. D. at Carroll county General West minster, MD 21157 Hospital at 200 memorial Avenue 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

JAN 1 9 1999



State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** TEAN Nelson Ruth 17, 1999 Jan, 3:40 AM /Medical 4e Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Salisbury Center; Genesis ElderCare Wicomico Salisbury, Md. If Under 24 Hrs. If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dev. Year) **Funeral** Deys Months Hours 10 M 20 F 67 220-26-2145 Director VIRGINIA JUNE 4,1931 Usual Residence of Decedent 10s Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show must be notified at Yes 2 No MARYLAND FRUITLAND WICOMICO Director 10e Street and Number 10f Zin Code 10g, Citizen of What Country? b 21826 U.S.A. 127 LIBERTY WAY "natural", or hems 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 9 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Hygiene. filled within Elementery/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filled wit timent of Health and Mental Hygien tant: If flam 25 is marked other the tiury or other traumatic event, the SALES CLERK RETAIL 17 Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be MARIE ETHEL BIRCH SEAMER WILLIAM KILLMON 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) SANDRA K. HARTMAN - DAUGHTER 6661 SNOW HILL RD. SNOW HILL, MD, 21863 Important: If Item 2 any injury or other 20b. Pleca of Disposition (Name of cametery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ⊠ Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL MEMORY GARDEN\$ 1-20-99 HEBRON, MD 21. Signature of Funerel Service Licensed 22. Neme end Address of Fecility 705 E. MAIN ST. CFSP SALISBURY, MD 21804 23a. Pert1. Enter the disease, or complications that baused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner con The law requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): attending p for usa as usa : P.O. ed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown þ Division of Vital Records, should l 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yee 2 ☐ No certificate Be 25. Was case reterred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. tnjury et Work? After or Attending 1 Neturel 5 Panding investigation 24 hours after death.

• Funeral Director: After detection of the function of 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 0 5 21804 QM 1104 HEALTHWAY DR., SALISBURY, MD. Dey. Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95

State

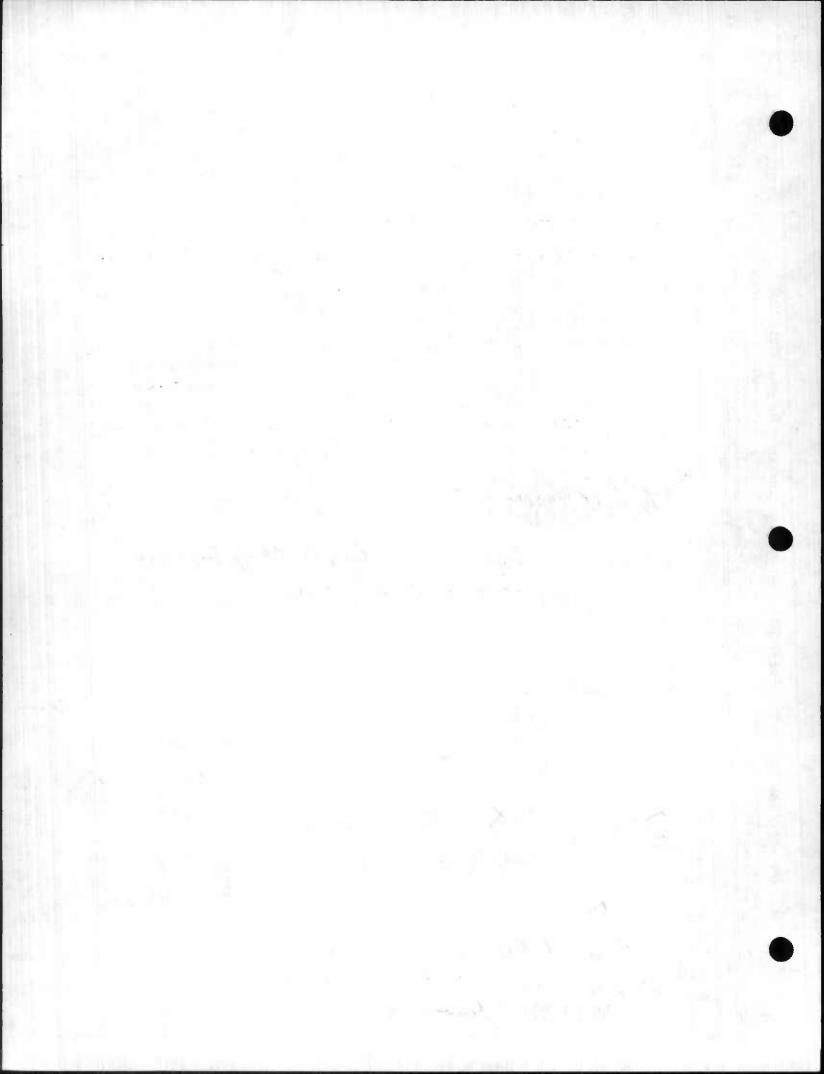
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State of Maryland / Department of Health and Mental Hygiene 02622

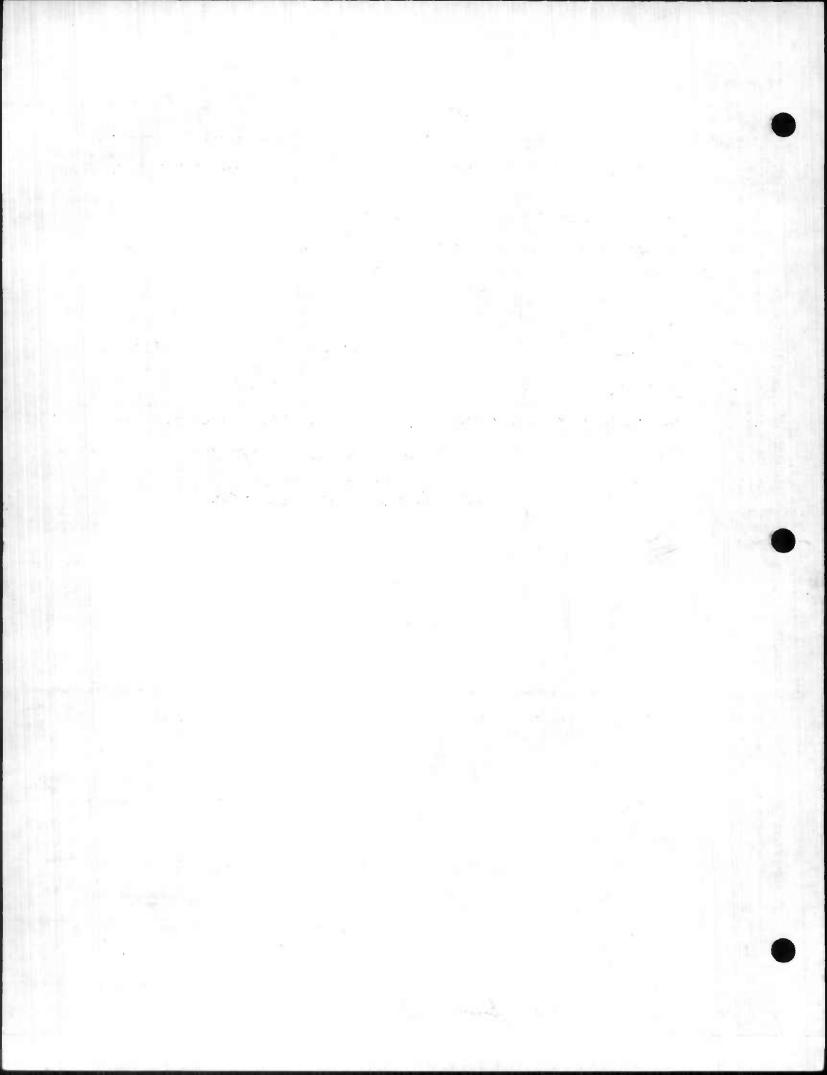
					Cei	rtificat	e of	Death			Reg. No.	() LM "		
Physic /Medi		Decedent's Name (First, Middle, I		s. 0'0	Connc	r				2. Date of De Month JANUA	Day	Year 1999	1620	PM
Exami		4e Fecility Neme (If not institution, g SHADY GROVE ADV						-	own, or Location of Death VILLE 4c. County of Death MONTGOMERY					
Funeral Director		5. Social Security Number 216-30-2546 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. last) 65	birthday) Yrs.	If Under Months		If Under Hours		8. Date of Birth (Month, Day, Year) January 23, 1933 9. Birthplace (State or Foreit Country) Washington, D. (
deeth with the Maryland rms 23s or 28s-f show	tor	10a. Stele 10b. County Maryland Montgo	merv	10c. City, To	own or Lo					П		100	I. Inside Ci	ity Limits
with the 3e or 28e	I Director	10a. Street and Number 17551 Black				10f. Zip	Code 2087	4			10g. Citizen of V			
5 22	by Funeral	11. Marital Status 1 ☐ Never Merried 2 ☒ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces	No 1951-			dent of I- cify Cub		gin? (Spec , Puerto F	cify Yes or No lican, etc.)		ce - American	Indian,	13
72 hours natural;	eted	15. Decedent's (Specify only highest g	Education rade completed)	16	(Give	dent's Usua kind of wo	vk done	during most	t of workin	9	16b. Kind of B	b. Kind of Business/Industry		
d within giene.	Completed	Elamentary/Secondary (0-12)	College (1-4or	5+)	life. I	le Sp	se retire	er			Teleph		mpany	У
d 2 should be filled the and Mental Hygien 7 la marked other traumatic evant, its	a a	17. Father's Name (First, Middle, La:							3. Mother's Name (First, Middle, Maiden Surname)					
hould be d Mental rarked o	2	Thomas F. 19e. Informant's Name/Reletionship			Ob Adallia	an Addanas	100000				s Tucke	-	lada)	
d 2 s Ith an 17 la r		Barbara A. O'Co												071
mit. Peges 1 an parlment of Heal portent: If Itam 2 y Injury or other 66.		20a. Method of Disposition 1 ABuriel 2 Cremetion 3 4 Donetion 5 Other (Special	☐Removel from Stete	20b. Place ceme	of Dispo tery, cren	sition (Name	ne of other pla) Janua emeter	ry 23	Germantown, Maryland 20874 Date 1999 Coc. Location - City or Town, State Silver Spring, Marylan				
Deartiff. Per Department Important: any Injury once.		21. Signeture of Funeral Survice Lio 23a. Pent. Enter the disease, or co shock, or heert tailura. List on	keri	M00846	Rol 75.	Name ar bert A 57 Wis	Addre Puscons:	ss of Facilit mphrey in Aver	Funer	al Home ethesda	/Bethesda- Maryland	Chevy (Chase.	Inc.
Physician /Medical Examiner	ner	Immediata Causa (Final disease or condition rasulting in death)	· Cyphe Vovces								phoper		Onset and I	Death
certificate be executed ding physician and ise as the burial-fransit	VMedical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last	c	Due to (or es	a conseq	juence of):		,						
death c e attended for us	iclar	Part II. Other algnificant conditions	contributing to death b	out not resulting	in the u	nderivina c	ause oi	ren in Part I		23b. Did	tobecco use co	intribute to t	he cause (of death
hat the od by the detach	by Physician/										Yes 2□ No	3 Probe		Unknow
aw requ	Completed b								_		an autopsy ormed?	avail	e autopsy f able prior t pletion of d eath?	to
F	Сод									1,70	Yes 2□No	100	Yes 2□	No
Physician: The this certificate	8	25. Wes case raferred to medical exeminer?	Hospital:				100		of Death	(Check only	one)			
Physic r this c	2	1 Nas 2 No 27. Manner of Death	28a. Data of Inju		Outpatien Time of	100000	-	4U NU	-		dence 6 Ott			
ttanding death. stor: Affei the fune	Certification:	1 Naturel 5 Pending 2 Accident Investigati 3 Suicide 6 Could not determine	(Month, Da	jury - At home,	Injury	М		k?` Yes 2□	No	28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number			nber,	
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by		29a. Certifier La Certifying F	hysician: To the best							nd due to the				
in 24 I	edical		end menner st	examination i										s)
To the To the Comple	¥	29b. Signature and title of certifier 29c. License number 0.C.M.E.						29d. Dete signed (Month, Day, Year) January 20, 1999						
		30. Name and address of person who		death (Item 23s	a) (Type, enn S	Print) Stree	t, B	altim	ore,	Maryla	and 2120	1		
Sta	ate	31. Dete filed (Month, Day, Year)		rar's Signature	1		1							



State of Maryland / Department of Health and Mental Hygiene

	Ce	ertificate of Death	Reg	3. No. 99	2623							
Physician	Decedent's Nama (First, Middle, Last)		2. Data of Death Month	Day Year	3. Time of Death							
/Medical	ELLA E. OFFUTT	N 6% 7-3	JAN.	14, 199	9 4:30 PM							
Examiner	4a Facility Nama (If not institution, give street and number) 17060 King James Way, #613	4b. City, Town, or Gaithe:	rsburg	4c. County of Death MONTGO								
Funeral Director	5. Social Security Number 217-30-2732 6. Sex 1 □ M 2 ▼ 7. Age (In yrs. last birthda) 83 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) NOV . 28,	1915 Ma	place (State or Foreign ntry) ryland							
ž	Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or I	ocation		1	10d. Inside City Limits							
to for	MD Montgomery Gait	hersburg			1X Yes 2 □ No							
r tems 23s or 28s-f e close mant be notified Funeral Director	10e. Street and Number 17060 King James Way, #613	10f. Zip Code 20877	10	U.S.A								
air, or tems 23s or 28e-7 show Espainer must be notified at by Funeral Director	11. Marilal Status 1 Never Married 2 Married 3X Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No H Yes, Giva Year or Datas:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 (2XNo Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, Whita, Specify: B1	atc.							
marked other than "natural; or imatic evant, the Waldcal Earth To Be Completed by F	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king 10	6b. Kind of Business/In	dustry							
Con	6th	Housewife		Home								
Be very	17. Father's Name (First, Middle, Last)		na <i>(First, Middle, Mi</i> ttie Lor									
To	Washington Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Ru		-	Code)							
ne de la company		00 Warfield Rd.										
Important: If Itam 27 Is marked other than any Injury or other traumatic evant, the Manasses. Dates. To Be Comp	20a. Method of Disposition \$\tilde{\mathbb{E}}\text{ Burial } 2 \subseteq Cremation \ 3 \subseteq Removal from State \\ 20b. Place of Disposition \\ 20c. Removal from State \\ 20c.	position (Name of ematory or other place)	Date 20	Oc. Location - City or To	own, Stata							
important: If any injury or pncs.	Ash Memorial Cem. 1/20/99 Sandy Spring, MD Signatured Eneral Service Licenses SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850											
	23a. Part1. Enter the charse, or complications that caused the death. Do not exhock, or heart is in List only one cause on each line.			pt,	Approximate Interval Between							
sician edical	V		1> 1/4/ / 0	1	Onset and Death							
niner	Immediate Causa (Final disease or condition rasulting in death)	TRESUMATION THR	ALPHIAL H		que.							
ė l	Due to (or as a conse	equence of):		i	20 45080							
as the buriel-transit	Sequentially list conditions. b. TYPATOWN Due to (or as a conse	equence of):		1	90 1=1910							
	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events				20 Y FRIPS							
	that initiated events resulting in death) Last	equence of):		1	1							
ed for usa	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23b. Did tob	ecco use contribute t	o the cause of death?							
d by Physician's	CARONIC CIMPHAPETTS		1 Te	2 No 3 Pro	bebly 4 Unknown							
2 should			24a. Was an perform	ed?	fare autopsy lindings vailable prior to empletion of cause death?							
director, page Fo Be Com			1 ☐ Yes	200 No 1	☐ Yas 2☐ No							
Be G	25. Was casa raterred to medical axaminer?		ith (Check only one)								
6 =	1 Yas 2 No Prospital: 1 Inpatient 2 ER/Outpatie		man and a second second	ce 6 Other (Speci	fy)							
fund lon	27. Manner of Death 1 Detural 5 Pending (Month, Day Year) 2011 Accident invastigation 28. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	v injury occurred								
al Diractor: After the funering the funering Certification;	2 Accident invastigation 3 Suicide 6 Could not be determined 28a. Place of Injury · At homa, farm, s building, atc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,							
To the Funeral Diractor: After completely filled in by the fune Medical Certification	29a. Certifier (Check only one) 1 Certifying Physician: To tha best of my knowledge, dea 2 Medical Examiner: On the basis of axamination and/or i and manner stated.	th occurred at the tima, data and place restigation, in my opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as : te and place, and dua!	stated. to the cause(s)							
Me Me	290. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)							
	► Common MD	D00161	45	1/19/90	9							
	30. Name and address of person who completed cause of death (Item 23a) (Type	, Print) JYAAAY GROVE &	(D)	ROCKOIUE	NO							
State Registrar	31. Data liled (Month, Day Year) 1999 32. Registrar's Signature	land										

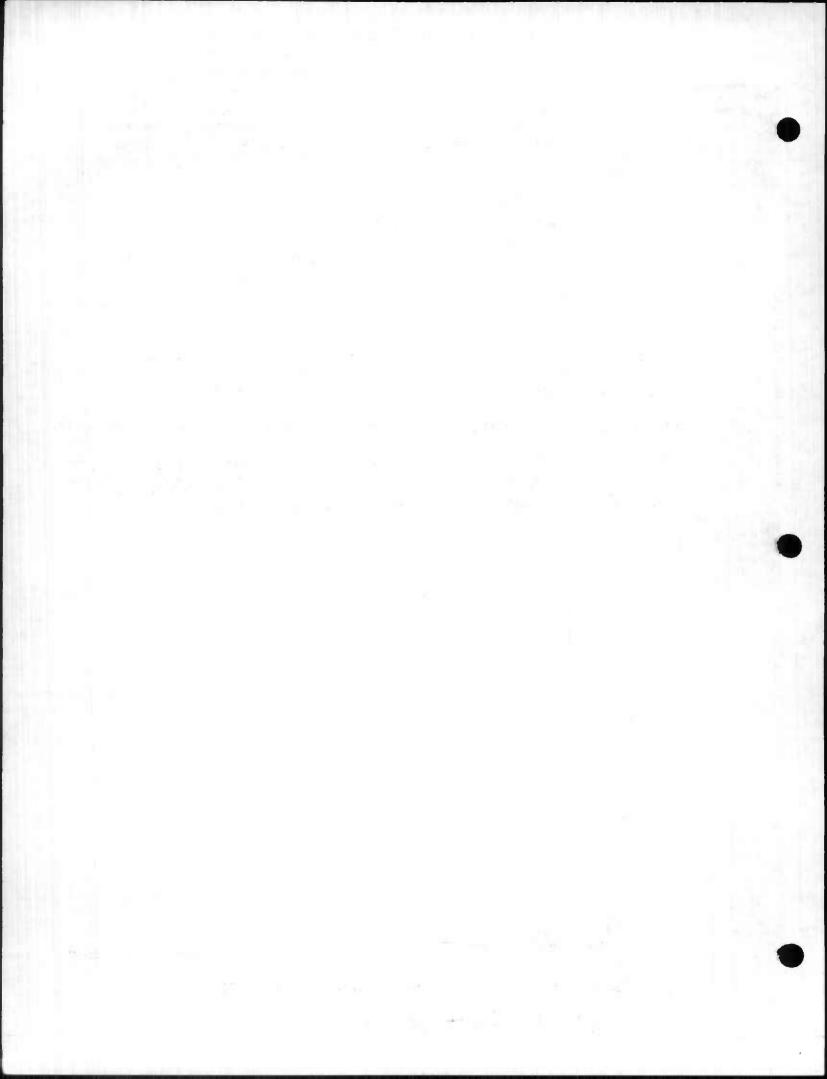
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 9	0262	ŀ
Certificate of Death		

						Cei	rtificat	e of	Death		Reg. No.		
Discolate	_	1. Decedent's Name (First,	Middle, La	st)						2. Dete of De Month	eth Dev	Year	3. Time of Deeth
Physician /Medical	_	Dorothy V.	Ogni	bene						Januar			2:00PM
Examiner	-	4a. Fecility Neme (If not Inst	itution, giv	e street and numb	er)				4b. City, Town, or			ty of Deeth	
	S	Shady Grove	Adv	rentist	Hosp	ital			Rockvil		Mon	tgom	erv
Funerai	1	5. Social Security Number 078-07-6071	6. 9	Sex 7. I□M 224F	Age (In yrs.	last birthday) Yrs.	If Under	r 1 Yeer Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da April	th		plece (State or Foreign flow) York
Director -	-	Usuel Residence of Decede	nt							APILL	, 1007	HEW	TOTA
how th		10e. Stete 10b. Co	ounty		10c. Ci	ty, Town or Lo	cation	_				10d. Inside City Limits	
be notified be notified Director	5	MD Mo	ntgom	nery	Si	lver Sp	ring						1 ☐ Yes 2 No
er 21		10e. Street end Number					10f. Zip	Code			10g. Citizen of	Whet Cour	ntry?
23a math	5	1127 Cresth	aven	Drive					20903			USA	
atural', or thems 23a or 28e1 show cal Examiner must be notified at ted by Funeral Director	5	11. Meritel Stetus 1 □ Never Married 2□ 3 ☑ Widowed 4 □ Divi		12. Wes Decede Armed Force 1 Tes 2 If Yes, Give Yeer or Dete	es? ∑No				Hispanic Origin? (S ben, Mexicen, Puert Specify:	pecify Yes or No to Rican, etc.)	- 14. Ra Blo Speci	ice - Americ eck, White,	
ygene. Ne than "natural", It, the Medical Exa	3	15. Dec	edent's Ed	ducetion		16e. Deced	lent's Usu	ei Occu	petion	.00	16b. Kind of I	Business/In-	dustry
of other than "n event, the Medi	-	Elementery/Secondery (0		de completed) College (1-4	or 5+)	life.	DO NOT u	se retire	during most of world)	rking			
Con		12				Home	emake	r			Own H		
Be	3	17. Fether's Neme (First, Mi							18. Mother's Nar	Meiden Sume	me)		
		Michelangelo					Maria Graziano						
- 10 年 - 10		19e. Informent's Neme/Reio							t end Number or Ru				
Heath and Mer ham 27 is marks other traumatic TO		Peter J. Ogn 20e. Method of Disposition	ibene	s (so					ven Drive	, Silver	-		
0 = 0	1	1 Burial 2 ☐ Creme			ILE	Plece of Dispo cemetery, cren					20c. Location		
rtant: it	-	4 Donetion 5 Oth			Ga	te of	Heave	n C	emetery 1	./23/99	Silver	Sprin	g, MD
Department of heath important: If hem 27 any injury or other to once.		21. Signeture of Funeral Se	IVIO LICER	1	2	Hc	. Name er	Inc	ess of Facility Fr 500 Un	ancis J. iversity	Blvd.	ns Fui West	neral
	4	feath.	for	unt		Si	lver	Spi	ring, MD	20901			
	1	23e. Pert1. Enter the shock, or heer	e, or com List only	plicetions thet cau one ceuse on eec	sed the deer n line.	th. Do not ent	er the mod	de of dy	lng, such es cerdied	or respiretory e	rrest,		Approximete Interval Between
ysician Medicai		Immediate Ceuse (Final										1	Onset and Deeth
aminer		disease or condition resulting in deeth)		e. Ren	al Fa	ilure							1 year
a				4.1		or es e conseq							
n end iel-transit Examiner				b. Ath		lerosis							10 years
in en iei-tra		Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Disease or injury			Due to (c	or es e conseq	uence or):						
g physician end as the buriel-transit ledical Examin		thet initieted events	4	C	Due to (c	or es e conseq	neuce of).					-	
		resulting in deeth) Lest			0001010	03 0 0011304	a01100 01).						
				d								i	
e att	F	Pert II. Other significant cor	nditions o	ontributing to deat	but not res	ulting In the ur	nderlying o	euse gi	ven in Pert I.	23b. Did	lobacco uas c	ontributs to	o the causs of death?
d by the attendilletached for use	ì	Canarono								10	Yes 2 No	3 Pro	bably 4 Unknown
o se		Gangrene											
2 should										24e. Wes perfo	en eutopsy med?	av	ere autopsy findings eilebte prior to impletion of ceuse deeth?
page Com										10	res 2⊠ No	10	☐ Yes 2☐ No
actor.	2	25. Was case referred to me exeminer?	dicel	Hoosite t						eth (Check only o	nne)		
T di		1 ☐ Yes 2 ☒ No		Hospitet: 1 🖾 Inp		ER/Outpetien		JA		lome 5 Resid			y)
After	2	27. Menner of Deeth 1 ☑ Neturel 5 ☐ P		28e. Dete of t (Month,	njury De <i>y Year)</i>	28b. Time of Injury		28c. Inju Wo		28d. Describe	now injury occu	irred	
1 1 0 a		3 ☐ Sulcide 6 ☐ C	vestigetion ould not be		Iniue Ast	omo forma	M factor		Yes 2 No	28f Location (Stroot and M.	har or D	al Route Number,
Direct d in by		4 ☐ Homicide de	etermined	building,	etc. (Specif	ome, ferm, str y)	et, tector	y, office		City or To		Der or Hurs	al Houle Number,
To the Funeral Direction of the Medical Certi	2	29a. Certifier 1⊠ Cer (Check only one) 2 Med	tifying Phylical Exam	ysician: To the be	of examina	wledge, deeth	occurred restigation	et the ti	lme, dete end ptace oplnion, death occu	, end due to the irred et the time,	ceuse(s) end ri dete end ptece	nenner as s , end due to	iteted. o the cause(s)
Mec Mec		29b. Signeture eng title of ce	rtifier	1//			290	c. Licen:	se number		29d. Date sign	ed (Month.	Dey, Year)
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	- 1	Name and add ss of pe Raymond Bass			•		Print)			20006		, 20,	1,,,,

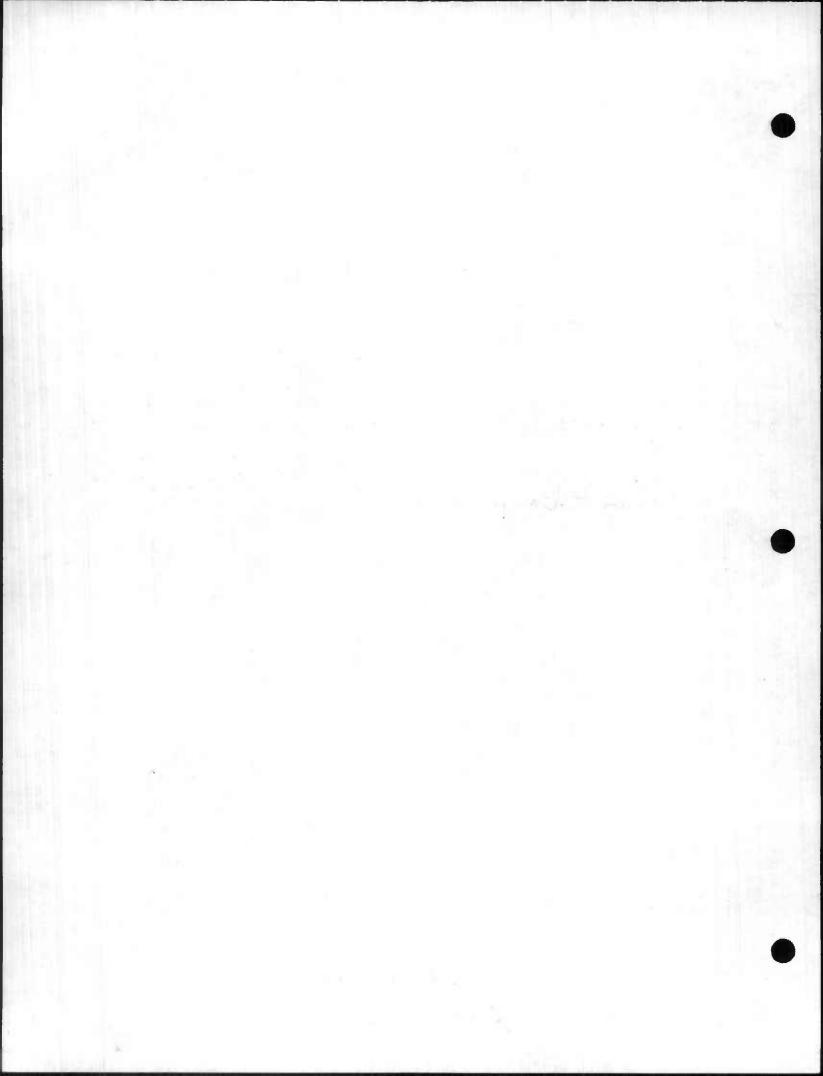
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State of Maryland / Department of Health and Mental Hygiene 99 02625

Certificate of Death Reg. No. 99

				Certifica	ate of	Death		Reg. No.	02020			
Physician	1. Decedent's Name (First, Middle, Luther A. Olso				1-		2. Date of D Month	Day Y	3. Time of Dea			
/Medical								6,1999	07:30pm			
Examiner	4a Facility Name (If not institution, Holy Cross Hos					4b. City, Town, Silver		4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 501-16-7402	5. Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birth 74 Y	Month	ler 1 Year s Days		Ain. (Month. D	orth 1924No. 1924No.	Birthplace (State or For Country) orth Dakota			
y .	Usual Residence of Decedent											
with the Maryland a or 28a-f show Use notified at Director	Maryland Montgo	omery	10c. City, Town		5				10d. Inside City Lin 1 ☐ Yes 2 🖔			
or death with the Marya harm 23s or 24s-1 shon ner must be notified at funeral Director	10e. Sfreet and Number 4231 Isbell Stre	et			Zip Code			10g. Citizen of What Country? United States				
r Rama 23 siner must Funeral	11. Marital Status	12. Was Decedent		1		Hispanic Origin?	(Specify Yes or Nuerto Rican, etc.)		American Indian,			
by F	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? d 1 ⊠ Yes 2 □ I if Yes, Give Year or Dates:			2X No		Jerto Hican, etc.)	Specify:	Black, White, etc. Specify: White			
vgiene. ve than 'natural'. r. the Medical Ex.	15. Decedent's (Specify only highest		16a. C	Pecedent's Us Give kind of v	suai Occu vork done	pation during most of	working	16b. Kind of Busin	ess/industry			
The Party	Elementery/Secondery (0-12)	College (1-4or 5	5+)			peciali		Weather	Ruraau			
	17. Father's Name (First, Middle, L	est)		Olmati	LOII	+		e, Maiden Sumame)	buleau			
Mental H mrked off rife even To Be	Oscar P. Olson						P. Bratla					
and Maria	19a, Informant's Name/Relationshi	p (Type, Print)	19b. I	Mailing Addre	ss (Stree			ber, City or Town, Ste	ate. Zip Code)			
eath ar ar trau	Dora C. Olson/Wi							oring, Mar				
3 4 6	20a. Method of Disposition	.re	1 10	h.t				20c. Location - Cit				
Separtment of reportant: If my injury or fice.	1 M Buriai 2 Cremation 3 4 Donation 5 Other (Special Service Li	ecify)	Parkla	wn Mem	oria	1 Park	obert A.	Rockville Pumphrey Montgomer	e, Maryland Funeral Hor y Avenue			
nysician	23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused any one cause on each line	the death. Do no			Maryla ing, such es care		0-3501 arrest,	Approximate triterval Betwee Onset and Deat			
Medical xaminer	Immediate Cause (Final disease or condition resulting in deeth) Sepsis Due to (or es e consequence of): Due to (or es e consequence of): days											
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min min		b. pneumon		200000000000000000000000000000000000000	۸.				, ady 5			
ling physician end se as the burial-transit												
e ettending physician end ad lor use as the bunal-transit included to the standard of the stan	resulting in death) Last	d	Due to (or as a co	nsequence of	1):				1			
ed by the ettendir detached for use / Physician/N							1		i			
ched ched	Part II. Other eignificant condition	a contributing to death b	ut not resulting in t	he underlying	cause gi	ven in Part I.			bute to the cause of de			
58 5				4			_	Yes 2 No 3	Probably 4/2 Uni			
2 should							24a. Wa per	s an autopsy formed?	24b. Were autopsy findi available prior to completion of caus- of death?			
page Corr							10	Yes 2 No	1 ☐ Yes 2 ☐ No			
certificate rector, pag	25. Was case referred to medical					26. Place of	Death (Check only	one)				
s certificate ha director, page To Be Com	examiner?	Hospitai:	ent 2 ER/Outp	atient 3 1	DOA O	her: 4 Nursin	ng Horne 5 ☐ Rea	sidence 6 Other	(Specify)			
her thi	27. Manner of Death 1. Netural 5 Pending 2 Accident Investigs	28a. Date of Inju (Month, Da	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Nork? 28c. Injury at Work?					Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
within 24 hours after deeth. To the Funeral Director: After to completely filled in by the funer Medical Certification:	3 Suicide 6 Could no determin		ury - At home, farn c. (Specify)	n, street, fact	ory, office			(Street and Number own, State)	or Rural Route Number,			
in 24 hour he Funera pletely fille edical (Physician: To the best of caminer: On the basia of and manner sto	examinetion and/									
Vithin Somp	29b. Signature and title of certifier			2	9c. Licen	se number		29d. Date signed (Month, Day, Year)			
	My	Ja Mp	113		1)-	32332		Jan 19,	1999			
30+1	30. Name and address of person w Suresh K.Gupt	no completed cause of d			ilve		g,Md 2090					
	1			WAS 2	TTAG	- abring	5 FIG 2090	-				
State Registrar	31. Date flied (Month, Day, Year)		ar's Signature	9 1	On V	41						



State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 6 2 6

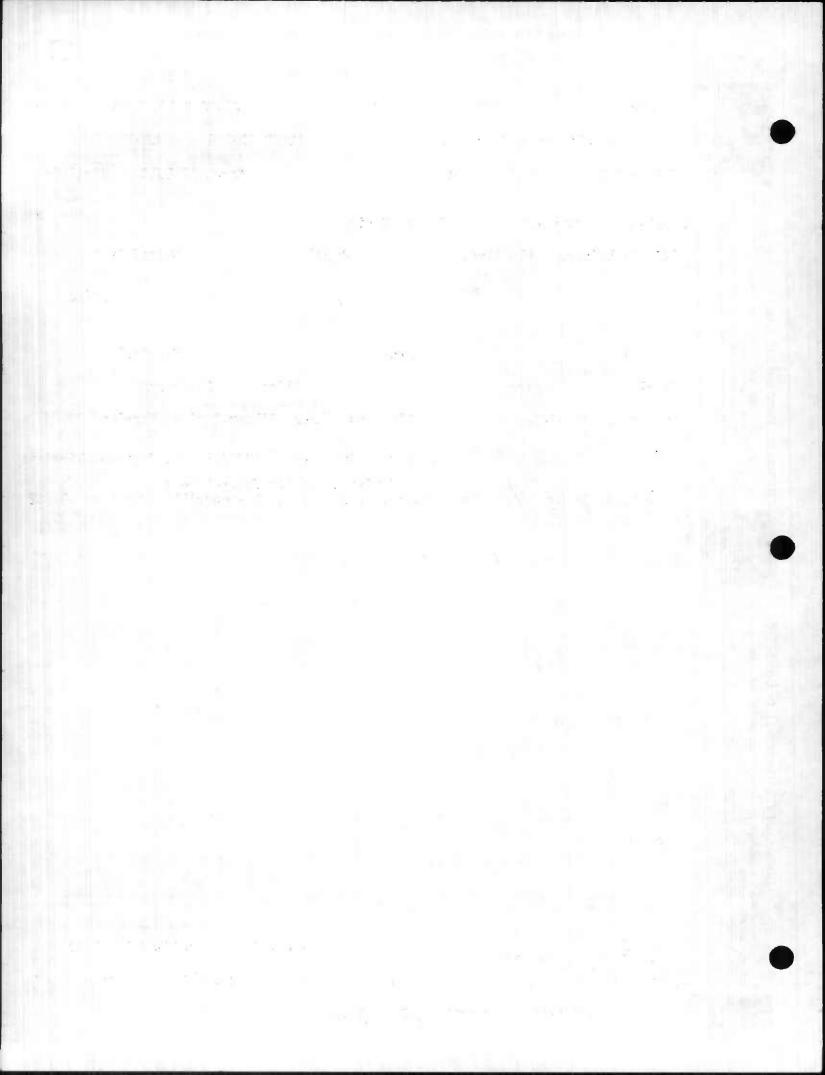
				Certificate	of I	Death		R	eg. No.		Lon O Em		
	Decedent's Name (First, Middle, Last)								Date of Death Month Day Year			Death	
Physician	SOL OREMLAND								Month Day Ye 01.13.1999			AM	
/Medical Examiner	4a Facility Name (If not institution, gir		4b. City, Town, or Lo				4c. County						
	HOLY CROSS HOSPITAL				5	SILVE	R SPI	RING	MONTGOMERY				
Funeral Director		Sex 7. A		Yeer	If Under : Hours	Min.	8. Date of Birth (Month, Day, Year) 9. Birthptace (State Country) 10.21.1916 NEW YORK				or Foreign		
2	579.07.8755 XEM 2017 82 Yrs. 10.21.1916 NEW YORK Usual Residence of Decedent												
the Merylar 28s-f show noutled at	10a. State 10b. County 10c. City, Town or Location								10d. Inside City Lir 1 ☐ Yes 2				
vith the Me or 28a-f s be notified Director	MARYLAND MONTGO	SPRING	PRING										
23a or 2	10e. Street and Number 10f. Zig 11505 LOCKHART PLACE 209							· ·	10g. Citizen of What Country? USA				
thems her dec	11. Maritat Status 1 Never Married 25 Married	12. Was Decedent Armed Forces 1 Yes 2 Il Yes, Give	?	ff Yes, specify Cuben; Mexican, Puer 1 ☐ Yes 2 No Specify:			gin? (Spe , Puerto I	cify Yes or No- Ricen, etc.)		can indien, etc.			
"natural", or	3 Widowed 4 Divorced	Year or Dates:	160							HITE			
n 72 nat legic	(Specify only highest gr	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry			
ed within 72 ho ygiene. Nor than "naturn it, the Magical Completed	Etementary/Secondary (0-12)	Etementary/Secondary (0-12) College (1-4or 5+)			SALES					TIRE			
E I 5 5 4	17. Father's Name (First, Middle, Last)								First, Middle, Meiden Surname)				
id be lental ked o	BENJAMIN OREMLAN			ANNA	RITE	RTN							
	19a. tnlormant's Name/Retationshtp	19b.	9b. Malting Address (Street and Number or Rural Route					Number, City or Town, State, Zip Code)					
2 2 2 5	ETHEL OREMLAND/W	D/WIFE		1505 LOCK	KHAF	ART PLACE		SILVER	SPRING	, MD	20902		
T Se H	20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State									DOTAIT			
permit. Pages Depertment of Important: If i eny injury or once.	4 Donation 5 Other (Special Service 21, Signature of Funeral Service 21	-	ILINO I					./13/33	PALILS	CHURC	JI, VI.	RGINI	
	21. Signature of Funeral Service Community EDWARD SAGEL FUNERAL DIRECTION, INC.												
	1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852												
	Approximate the disease. It complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, and or heart failure. List only one cause on each line. Approximate the mode of dying, such as cerdiac or respiratory arrest, and or respiratory arrest. Onset and Death												
Physician / /Medical	Immediate Cause (Final	0											
Examiner	Immediate Cause (Final disease or condition resulting In deeth) Preumoria 2 weeks										160		
			Due to (or as a d	consequence of):									
death certificate be executed e ettending physicien and ed for use es the bunel-transit siclar/Medical Examinel		b								<u> </u>			
cate be executed physician and sthe buriel-transit	Sequentially list conditions, if any, teading to immediate	Due to (or as a consequence of):											
Solciar Duni													
ing physicia e es the bu	resulting in death) Last Due to (or as a consequenca of):												
use e		d											
ettending platfor use es l	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given						n in Doubt					of death ?	
							23b. Did tobacco use contribute to the cause of death?						
ned by the state detection of the detect	Chronic a	fihi	lation				101	1 Yes 2 No 3 Probably 4 Unknown					
tate hes been signed to page 2 should be det	Chronic atrialfil Diabetes mellitus								e. Wes an autopsy performed? 24b. Were eutopsy lindings available prior to completion of cause of death?				
8 0 D													
page Con								1 🗆 Y	es 2 No	1	☐ Yes 2□	No	
ysician: The list of sector, page director, page	25. Was case referred to medicet examiner?						of Death	(Check only or	7e)				
	1 Yes 2 No	Hospital: 1 Inpat	Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing H						lome 5 ☐ Residence 6 ☐ Other (Specify)				
ng Ph ter th neral	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Uponth, Day Year) 28b. Time of Work? 28d. Describe how injury occurred Work?											
Attending or death. ector: After by the fune iffication	2 Accident investigation	M 1 Yes 2 No											
tal or Attending P rs after death. el Director: After t led in by the funers Certification:	3 Suicide 6 Could not to determined	28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)					1	281. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After the Compiletely filled by the funeral Medical Certification:	29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) end menner es stated. 29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) end menner es stated. 20 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner es stated. 21 A Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) end menner es stated. 22 A Certifier (Check only one)												
Mec the	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year								, Day, Year)				
F3F8	1 70/0-1	1	D 0143 Md 1/13/99						>				
25	11/100-1:01/1-												
	30. Nerrie and address of person who				000	-		000 T1-0	100 00	010			
		3		STREET#	230	, SIL	VER :	SPRING,	MD 20	910_			
State	31. Date lited (Month, Day, Year)		rar's Signature	4 las	. 1	/							

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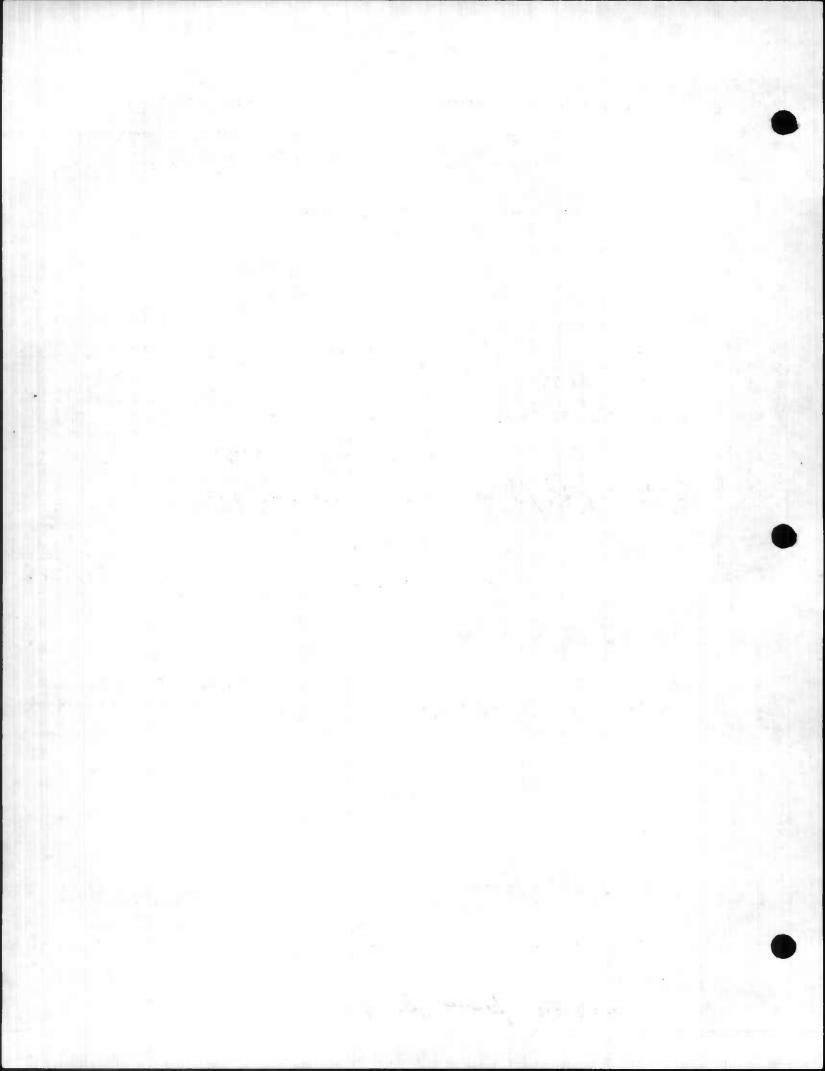
State of Maryland / Department of Health and Mental Hygiene 9 0 2 6 2 7

	Certifica	ite of Death	Reg	g. No.	
Dhusisian	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Ye	3. Time of Death
Physician /Medical	AVA EVE OTT		JANUARY	18, 199	
Examiner	4a Facility Name (If not institution, give street and number) 3235 S. LEISURE WORLD BLVD.	4b. City, Town, or E SILVER S	PRING	4c. County of D MONTG	OMERY
uneral director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Months Usual Residence of Decedent	er 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day,) March 17	1913 9.	Birthplace (State or Foreig Country) Virginia
MON THE	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
be notified at Director	Maryland Montgomery Silver Spring 100. Street and Number 101. Z	n g Cip Code	100	g. Citizen of What	1 ☐ Yes 2 🕅 No
Sa or	3235 S. Leisure World Blvd.	20906		United S	States
natural, or items 23s oficial Examines must leted by Funeral I	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 25 No Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc. White
n, the Medical Ex-	15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of w	sual Occupation	(Ing	6b. Kind of Busine	ess/Industry
- 31 0	Elementary/Secondary (0-12) College (1-4or 5+)	vork done during most of work use retired)			
S S	12 0 Nurse	19 Mother's Nam	e (First, Middle, Ma	Hospital	
ed out	Charles Hepner	Alice	Sham	·	
If from 27 is marked other than or other traumatic svent, the Ma	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	ess (Street and Number or Rungo Place, Silv	ral Route Number,	City or Town, Sta	
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Herman	lame of rother place)	Date 20	Oc. Location - City	
important: any Injury pncs.	21. Signature of Funeral Service Licensee Murie	and Address of Essility	uneral Ho	me	
physician end street in the buriel-transit street in the buriel transit street in the buriel in the	Immediate Cause (Final disease or condition resulting in death) a. Parillo Solo" Due to (or as a consequence of any, leading to immediate				Inferval Between Onset and Death 5 7ems
Aedicai	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d	():			
ed for use est siclan/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	23b. Did tob	acco use contril	bute to the cause of death
igned by the attendir be deteched for use by Physician/A	preumonia		1 □ Yes	s 212No 31	Probably 4 Unknow
s been s 2 should pleted			24a. Was an perform		4b. Were autopsy findings available prior to completion of cause of death?
E 8 E			1 ☐ Yes	s 2 No	1 ☐ Yes 2 ☐ No
certificate irector, pag	25. Was case referred to medical examiner?		th (Check only one)	
는 다	15/Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 I		ome 5 Residen		Specity)
After funer funer	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Injury (Month, Day Year) 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factor	28c. Injury at Work? 1 Yes 2 No	28d. Describe how		or Rural Route Number,
Direction of the property of t	4 Homicide determined determined building, etc. (Specify)	ory, omeo	City or Town,		
To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one) 1 Certifying Physician: To the basis of my knowledge, death occurre and manner stated.				
Me Me		29c. License number	29	d. Date signed (A	fonth, Day, Year)
/	I Am a sa . mo	D24543	JA	NUARY 19	, 1999
>	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TYMES A - ROSS', MD 3305 Nonth Lethic				
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	rach/	1		



State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 6 2 8

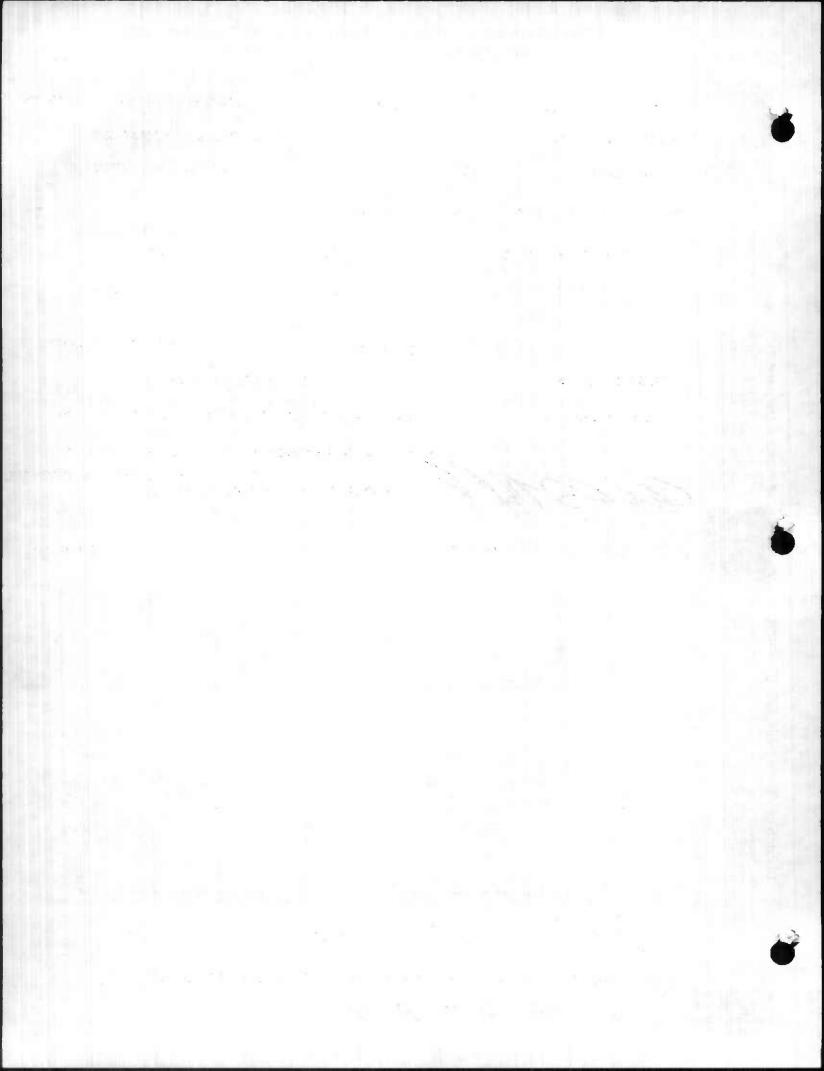
			Certificate of	Death		g. No.	02028
Physician	Decedent's Name (First, Middle, Last) TODD 7 This	D31111777			2. Date of Death Month	Day Yea	
/Medical	LORRAINE V					15,1999	1:20 AM
Examiner	4a Facility Name (If not institution, give street			4b. City, Town, or Loc		4c. County of De	
	Holy Cross Hosp			Silver S		MONTG	
Funeral Director	5. Social Security Number 220-28-5955 Usual Residence of Decedent	280 F 8 6	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 29	,1912 9.8	irthplace (State or Foreign Sountry) Maryland
natural, or home 23a or 28a-f show of all Examiner must be notified at steed by Funeral Director	10a, State 10b, County	10c. City, T	own or Location				10d. Inside City Limits
notified at	MD Montgome	ery	Silver Sp	ring			1 ☐ Yas 2X No
234 or 2	3036 Bel Pre Roa	ad, #201	10f. Zip Code 2 0	906	10	g. Citizen of What G	
Especial Control of Proceedings of Puneral Director	1 Never Married 2 Married	Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub		cify Yes or No- lican, etc.)	14. Race - An Black, WI Specify: B	
Completed	15. Decedent's Education (Specify only highest grade co	on 1 mpleted)	6a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working)g 1	6b. Kind of Busines	s/Industry
Be Comp	Elementary/Secondary (0-12) 6 th	College (1-4or 5+)	Housew:			Home	
Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	laiden Sumame)	
	Perry Russell				nown		
To Be Co	19a. Informant's Name/Relationship (Type,		19b. Mailing Address (Street				
17.00	Antwan Pannell (1914 Denni				
ry or othe	20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Remo	I BIBIC IIIOII IBVC	of Disposition (Name of etery, crematory or other pla			Oc. Location - City	
any injury o	4 Donation 5 Other (Specify) 21. Supplying of Funeral Service Licensee	Gat	e of Heave		21/99	Silver	Spring, MD
a de	(Dance D)	mand	SNOWDE	N FUNERAI	HOME,	P.A.	
	23a. Part1. Enter the disease, or complication shock, or heart feilure. List only one complete the complete t	ons that caused the death. I				st,	Approximate
ician	snock, or heart lenure. List only one co						Interval Between Onset and Death
lical	Immediate Cause (Final	PNEUN	ONLA				12 HRS
ner	disease or condition resulting in death)						1-11-2
5		GO DTI	a consequence of):				12 HRS
al Examiner	b	2011	CEWILLI				
×	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						1
edical	resulting in death) Last	Due to (or as	a consequence of):				
- 5	d						
Fel				112			
9	Part It. Other significant conditions contribu			iven in Part I.	23b. Did tol	secco use contribu	rte to the cause of death?
by Physician/	UPPER YASTI	2011/95TL	NAC BLG	ED .	1 🗆 Ye	8 2 No 3	Probably 4 Unknown
Completed					24a. Was an perform		o. Were autopsy findings evailable prior to completion of cause of death?
Сотр					1 ☐ Ye	s 205-No	1 Yes 2 No
	25. Was case referred to medical			26. Place of Death	(Check only one	1	
ToB	examiner?	ital: ₩ Inpatient 2□ER	/Outpatient 3□ DOA Ot	hor		nce 6 Other (S)	nanihr)
			b. Time of 28c. Inju		-	w injury occurred	Jecny)
tlon	1 Netural 5 Pending investigation	(Month, Day Year)	Injury Wo	ork?]Yes 2□No			
Certification:	2 Suicido 6 Could not be	8e. Place of Injury - At home building, etc. (Specify)			8f. Location (Str City or Town,	eet and Number or State)	Rural Route Number,
To the Funeral Director: completely filled in by the Medical Certifical		n: To the best of my knowled On the basis of examination					
Med		manner stated.					
8	29b. Signature and title of certifier	LIN DHY	/C / Licen	7 フィ フ		d. Date signed (Mo	1000
	e www.	Las Lul	26/11/10/11/11/11	723	JI	+N 15"	1779
	30 Name and address of person who complete the complete t	eted cause of death (Item 23	(Type, Print) 114	DO ROCKVI	LLE PII	ce, Rock	VILLE, MARYLAN
State	31. Data filed (Month, Day, Year)	32. Registrar's Signature		,			
	IAM 1 0 1999	Black	D. Moule	0/			



State of Maryland / Department of Health and Mental Hygiene 9

					(Certi	ificate of	Death	_		Reg. No.		
Physician /Medical	1. Decedent's Nar GEORGE	me (First, Middle, La S			P	IKN			J	2. Dete of Do	28°, 19	9 ⁶ ar	3. Time of Death 9:45 P.
Examiner		(If not Institution, git VALLOW FA)		umber)				4b. City, Town SILV		ation of Deel		y of Deeth	Y
Funeral Director	5. Social Security 218-82-8	Company of the	Sex 12M 2□ F	7. Age (In	yrs. last birthe Yr	Jay	If Under 1 Year Months Days		Hrs. Min.	8. Date of Bi (Month, D JUNE 2	70 1949	9. Birthp	elece (State or Fore
P .	Usual Rasidenca	1		140									
ith the Marylar or 28a-f show be notified at Director	MD 10a. State	MONTGO	MERY		c. City, Town of ILVER								0d. Inside City Lim 1 ☐ Yes 2 🖔 I
r 28	10e. Street and No	umber					10f. Zip Code				10g. Citizen of	What Coul	ntry?
hwii 23a c	12029 ST	WALLOW FA	LLS CT.				20904				USA		
72 hours after death with the Maryland natural, or frams 23e or 28e-f show acel Evantrat mist be notified at steed by Funeral Director	10.00	rrled 2 X Married 4 □ Divorced	12. Wes Dec Armed F 1 Yes If Yas, G Yaar or I	orces? 20 No liva	in U,S.	Jf Y	as Decedent of F ras, specify Cub	an, Mexican, I	n? (Spec Puerto R	cify Yes or Ni Rican, etc.)	Ble	ce - Americ ock, White, fy: WHI	etc.
n 72 hours natural', edical Ex leted by	O E WIGOWOO	VE-21/2	-	Dates.	160 D	locada	nt's Heuel Occur	nation			16b. Kind of B	lucinece/in	duetor
na n	(Spe	15. Decedent's E ecify only highest gr	ede completed))	16a. U	Give kil	nt's Usuel Occup ind of work done O NOT use ratire	during most o	f workin	g	IOD. KING OF E	ousiness/iii	dustry
filed within 72 hor Hygiene. ther than "natura int, the Medical Is Completed	Elemantary/Sec 12	condary (0-12)	College ((1-4or 5+)			E D'	. ,			FOOD A	ND BE	VERAGE
EISE A	17. Father's Neme	S PIKNIS	()		1111					(First, Middle PETANA	, Meiden Surna KIS	тө)	
aith and Mental 27 is marked or r traumatic ave		Name/Reletionship				_	Addrass (Straet						
1 end Health em 27 other tr	20a. Mathod of Dis			2	Ob. Plece of D	Disposit	tion (Name of			Dete	20c. Location		
nt of nt of or	1 🖾 Burial 2	Cremation 3		State			EAVEN C		7 1-	23-99	SILVER	SPRIN	G. MD
permit. Pages 1 en Department of Heat Important: if item 2 any injury or other		5 Other (Special Service Lice	•	64	0	22. 1	Name end Addre	ess of Fecility	HIN	ES-RIN	NALDI 11		NEW HAMPS
nding physician and use as the burial-transit n/Medical Examiner	Immediate Cause disease or conditi resulting in death; Sequentially list of if eny, leeding to icause. Enter Uncause (Disease of that initiated even resulting in deeth)	conditions, immadiate derlying or injury	e. MET b	Dua	to (or es a co	nseque	enca of):						3-MONTHS
attar 3 for u	Part II Other sign	idia and ann didings	a a a tulbu utin m to	dooth but on	at manufalm — In t	da a conse	laukitan aawaa ak	una la Dant I		non Die	I tahanaa waa a	a manifes and a	o the cause of dea
requires that the death seen signed by the atten hould be dateched for u eted by Physiciar	Pert II, Other sign	ificant conditions	contributing to c	death but no	ot rasulting in t	ne uno	arrying cause gr	ven in Part I.			Yes 2 No		bably 4 Unkn
sw requires s been sign 2 should be pleted b									_	24a. Was	s an autopsy ormed?	94	era eutopsy finding reilabla prior to empletion of cause daath?
The lew ate hes page 2										1 🗆	Yes 2 No	11	Yes 2□ No
cartificate rector, pag	25. Was case refe	erred to medical						26. Place o	of Death	(Check only	one)		
this cartific ral director.	axa <i>m</i> iner? 1 ☐ Yes 2	No	Hospital:	Inpatient	2 ER/Outp	etient	3 DOA Ot			37	idence 6 🗆 Ot	har (Speci	(v)
	27. Manner of Dea 14. Natural 2 Accident	ath 5 ☐ Panding investigation	28a. Date (Mor		28b. Tir	me of	28c. Inju Wo M 1		2		how injury occu		
tal or Attending Price and Interest After the funeration: Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not i determined	1 Zea. Plac	ea of Injury - ding, etc. (S		n, stree	et, factory, office		2	28f. Location City or To	(Street end Num own, Stete)	ber or Run	el Route Number,
To the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)	Certifying Pl	miner: On the b	e best of my basis of exa nner stated.	y knowledga, o mination and/	daath o	occurred at tha ti stigation, in my o	ime, date and opinion, death	place, a	nd due to the	causa(s) and n , date end place	enner as s , end due t	stated. the cause(s)
To the	29b. Signature en	title of certifier	1	14	9		29c. Licens D417				29d. Date sign		Day, Year)
		tress of person who VENKATRAN						GREEN	BELT	, MD 2	20770		
State Registrar	31. Dete filed (Mo	nth, Dey, Year) AN 22 19		Registrer's	Signatura	9.	Sport	n					

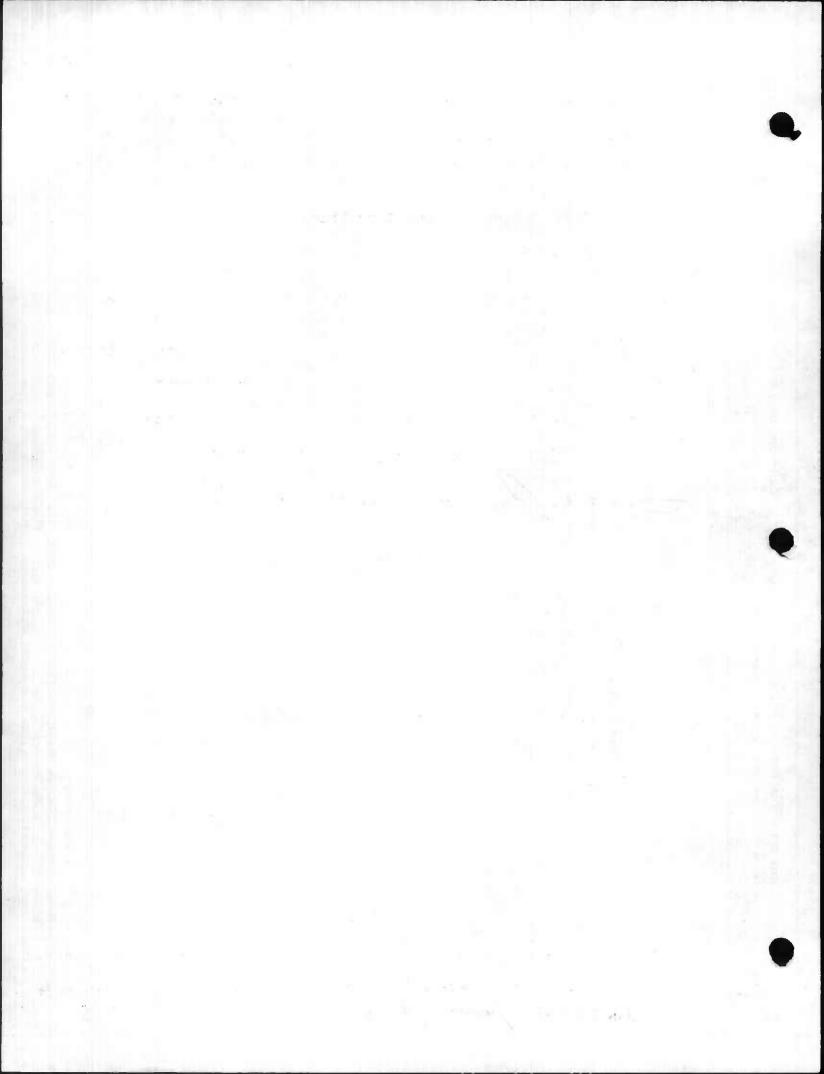
DHMH 16 Rev 6/95



Piease Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician	Decedent's Neme (First, Middle, La ALBERTA		TTS			2. Dete of Dea	_	Vone	Time of Death : 45PM
/Medical Examiner	ALBERTA 4a Facility Nama (If not institution, give Collingwood N	e street end number)			4b. City, Town, or L	ocation of Death	4c. County		
Funeral Director	5. Social Security Number 151-14-9401 Usual Residence of Decedent	Sax 7. Age (I	n yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days		8. Data of Birth (Month, De) Mar. 5	1922	9. Birthplace Country) FIOT	(State or Fore
ahow dan	10a. State 10b. County	10	Oc. City, Town or Lo	ocation					side City Lim
28a-f aho notified at		Georges	New (Carrollt	con	1			¶Yas 2□
r items 23s or 28s-fa other must be notified Funeral Director	10e. Street and Number 5432 85th Av	enue		10f. Zip Code	20784		U.S		
	11. Merital Status 1 Nevar Married 2 Merried 3 XWidowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 Yas 2 No If Yes, Give Yaar or Datas:	ar in U,S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, atc.)	14. Race Black Specify:	e - American Ind. k, White, etc.	
nor than "natural", of it, the Medical Example Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondery (0-12) 12th	ducation ada complated) College (1-4or 5+)	16a. Dece (Giva life.	dent's Usuel Occup kind of work done DO NOT use retire Clerk	pation during most of work id)	ing	16b. Kind of Bu		
- 5 E	17. Father's Nema (First, Middle, Last)		0027	18. Mother's Nam	e (First, Middle,			
P P B	Leroy Bright				-	Ann Ga			
DE E	19e. Informent's Neme/Reletionship (Donald Kendle				t and Number or Rui Ave., Ne				
Department of Heelth Important: If Nem 27 is any injury or other truence.	20e. Method of Disposition 1 Buriei 2 Cremetion 3 4 Donetion 5 Other (Specif	Removal from Stata	20b. Plece of Dispo	osition (Name of metory or other pla		Date	20c. Location -	City or Town, S	Stete
attending physician and local care burial-trensit if for use as the burial-trensit clar/Medical Examiner	23a Fart Eme the disease, or comshock, or heart fellule. List on Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. CISP bu b		quence of):	esmor			inter	roximate roximate
ed by the adeteched f	Pert It. Other significant conditions of	contributing to death but n			von in Part i.	400	obacco use cor	atribute to the 3 ☐ Probably	
been sign should be leted by	herripar	2512	oq etto	21/11/200	z no e car e	24a. Wes	an autopsy med?	24b. Were as available complet of death	e prior to tion of cause
page 2	SIPCUA					101	es 200 No	1 □ Yes	s 200 No
s certificate director, pag To Be Co	25. Was case referred to medical examiner?	Hospitel:		- Ot	26. Place of Dee				
ther thinneral	1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending Investigetio			f 28c. Inju		ome 5 Resid	ence 6 LIOtherow injury occurr		
el Direction by	3 ☐ Suicida 6 ☐ Could not b determined	building, etc. (Specify)			City or Tou			
n 24 hou he Funer pletely fil edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	nyalcian: To the best of n niner: On the basis of ex end menner stete	aminetion end/or in	h occurred at the ti vestigetion, in my	ime, date end place, opinion, deeth occur	end due to the or red at the time, or	ause(s) and ma date and piece, s	nner as stated and due to the	cause(s)
C 2 5 A	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed	d (Month, Day,	Year)
To the									
To the Comple	30. Neme and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)	10 loca	-8 -	Janua	my 1-	+, 199

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** 13, 1999 George January 10:40 PM Plungas | /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. Yrs. Director 272-01-4737 81 Nov. 1, 1917 Ohio Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 TXNo Directo Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23s or edical Examiner must be 10111 Lakewood Drive 20850 United States permit. Pages 1 and 2 should be filed within 72 hours efter death a Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or flams 23 any injury or other traumatic event, the Medical Expension mass. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 12 Yes 2 No If Yes, Give Year or Dates: 1942/1946 Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2⊠ Married 1 Yes 2 No Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Self Employed 12 Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Plungas Peter Barbara Sielakas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 10111 Lakewood Drive, Rockville, Maryland 20850 Gay Plungas/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/18/99 Gaithersburg, MD. 4 ☐ Donetion 5 ☐ Other (Specify) Forest Oak Cemetery Cigneture of Funeral Service License 22. Name and Address of Fecility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Finel disease or condition resulting in death) /Medical , Parkinsons Disease Examiner Due to (or as a consequence of): Examiner physicien end the burial-transit Sequentiatly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): 97 950 0 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown signed t Pneumonia by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed page 2 s 1 Yes 2 No certificate 1 Tyas 2 No funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2♥ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28c. Injury at Work? 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation 1 Natural after death. 1 Tyes 2 No 2 Accident A 24 hours after dea Ne Funeral Director pletely filled in by th 6 Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Andlow michael 10+1 January 14, 1999 D 29730 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Yeer)

JAN 19 1999

16220 Frederick Rd., # 210, Gaithersburg, MD. 20877 James M. Anchors, M.D., 32. Registrar's Signature Sparky

DHMH 16 Rev 6/95

the Maryland

with

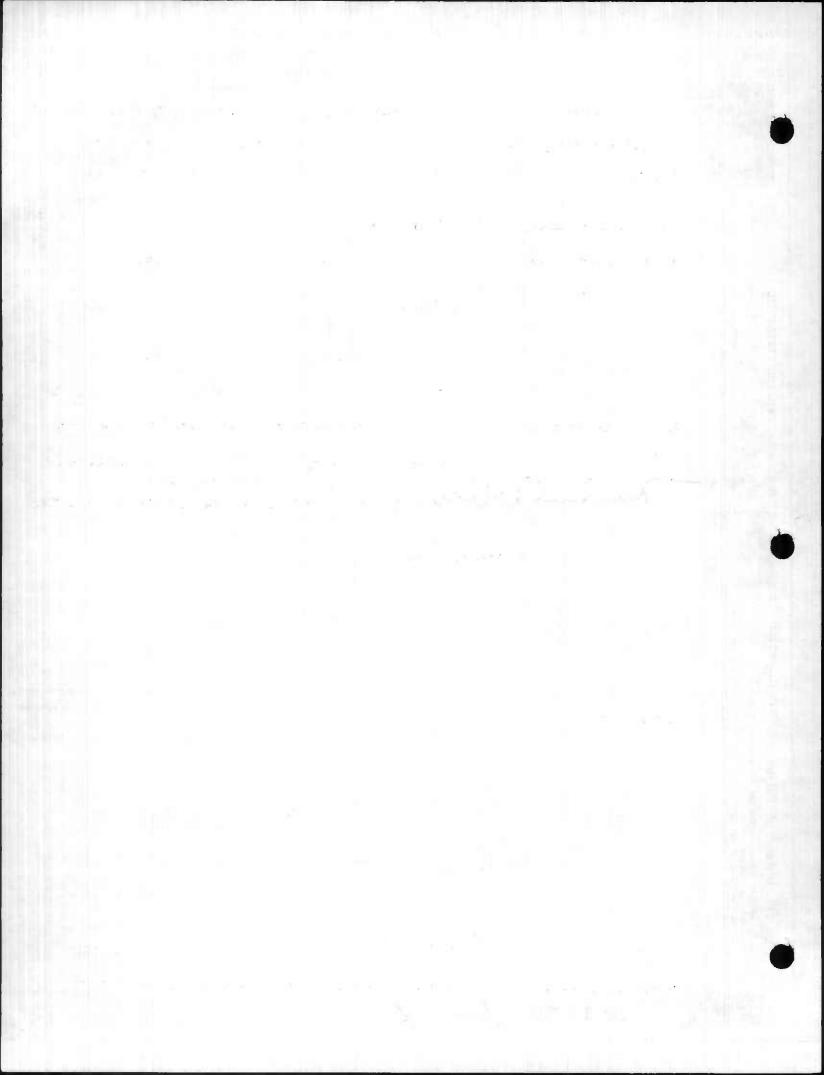
Baltimore, Maryland 21215-0020

requires that the death certificate be executed

Attending Physician:

Hospital or

Division of Vital Records, P.O. Box 68760,



permit. use as the burial-transit etained by the hospital or should be detached for

notified pe must

10

CERTIFICATION

MEDICAL

PHYSICIAN:

ВҰ

COMPLETED

BE

2

IMMEDIATE CAUSE (Final

Sequentially list conditions.

if any, leading to immediate cause. Enter UNDERLYING

CAUSE (Disease Dr Injury

that initiated events resulting in death) LAST

disease or condition

resulting in death)

BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with fours after death. Page 6 may be re	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be no
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	1 - FOR STATE REGISTRAR	STATE OF MA		/ DEPA					MENTAL HYGIENI REG. NO.	E			
	1. OECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH		YEAR	3. TIME OF DEATH	
	BENJAMIN SAMUEL	POKROY							01.12.199	9	TEAR	6:45 AM	A
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	. AGE (in yrs.	last birthday		DER 1 YEAR	IF UNDER		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH	IPLACE (State or Foreign	_
	213.09.8131	1 GM 2 GF	85	YRS.	MONTH	DAYS	HOURS	MIN.	11.19.191	3	Courn	" PA	
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. C	TY, TOWN	OR LOCATI	ON OF DE	ATH	9c. COU	NTY OF D	DEATH	
5	HEBREW HOME OF G	REATER WAS	SHING	TON	RC	CKVI	LLE			MON	rgom	ERY	
5	RESIDENCE OF DECEDENT						•						
	MARYLAND 10b. COUNTY MONTO	OMERY		10c. C	TY, TOW	H OR LOCA		LVE	R SPRING			10d. INSIDE CITY LIMITS?	
ונ	10e. STREET AND NUMBER					1 40	1. ZIP COD			Teal are		1 YES ZY NO	_
2	9 WOLF DRIVE									15		WHAT COUNTRY?	
							20904			US	SA.		
5	11. MARITAL STATUS 1 Never Married 2 Merried		YES 2	ARMED NO	1				HC ORIGIN? (Specify Yea n, Puarto Rican, etc.)	or No-	14. RACI	E — American Indian, k, White, etc.	
0	3 Widowed 4 Divorced	IF YES, GIVE WAR		WW II		1 TYES	2 XNO	Specify	T		Spec	W WHITE	
ב	15. DECEDENT'S EDUI (Specify only highest grade	CATION completed)	18a.	DECEDENT				na .	18b. KIND OF BUS	INESS/INC	DUSTRY		_
9	Elementery/Secondary (0-12)	College (1-4 or 5+)		life. Do NOT	use retired		out of Frontis				_		
L	12		Ρ.	ROCES	SUR				GOVER	MEN'	[,		
3	17. FATHER'S NAME (First, Middle, Last) LEWIS POKROY								ME (First, Middle, Malden	Sumame)			
								EDA I					
5	19a. INFORMANT'S NAME (Type/Print) LARRY POKROY/SON								Route Number, City or Town			22252	
				1130	ו וע	INTET	IH PI	ACE	GAITHERS	BURG,	, MD	20878	
	20a. METHOD OF DISPOSITION 1 Remidel 2 Cremation 3 Ram	oval from State	20b. PLA	CE AND DATE	other place	OSITION (N	ame of		DATE 20c. LO	CATION -	City or To	own, Stata	
	4 Donation 5 Other (Specify)	1	JUD	EAN M	EMOF	TAL (GARDI	ENS C	01.14.99 OI	NEY	MAI	RYLAND	
	21. SIGNATURE OF PUNERAL SERVICE LIC	Mark			1 2	2 NAME A	NO ADDRE	SS OF FAI	UNERAL DIE				

PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🛛 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 - YES 2X NO t 🗆 Inpatient 2 🗆 ER/Outpatient 3 🗀 ne 5 🗆 Realdence 8 🗀 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Netural
2 Accident М 1 YES 2 NO Investigation 3 Sulcide 28a. PLACE OF INJURY — At homa, farm, straet, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Homicide 1X CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(a) end menner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner as stated.

or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reapiretory arrest,

1091 ROCKVILLE PIKE, ROCKVILLE, MD

DR. KIRTI VOHRA, 1299 LAMBERTON DRIVE, SILVER SPRING, MD 31. DATE FILED (Month, Day, Year)

JAN 19 1999 32. REASTRAR'S SIGNATURE

296. SIGNATURE AND TITLE OF CERTIFIER

shock, or heart failure. List only one cause on each line

C.O.P.D.

0

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

D.M.

CANCER OF THE LIVER

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

HYPERTENTION
DUE TO (OR AS A CONSEQUENCE OF):

29c. LICENSE NUMBER

D20274

29d. DATE SIGNED (Month, Day, Year)

20902-3411

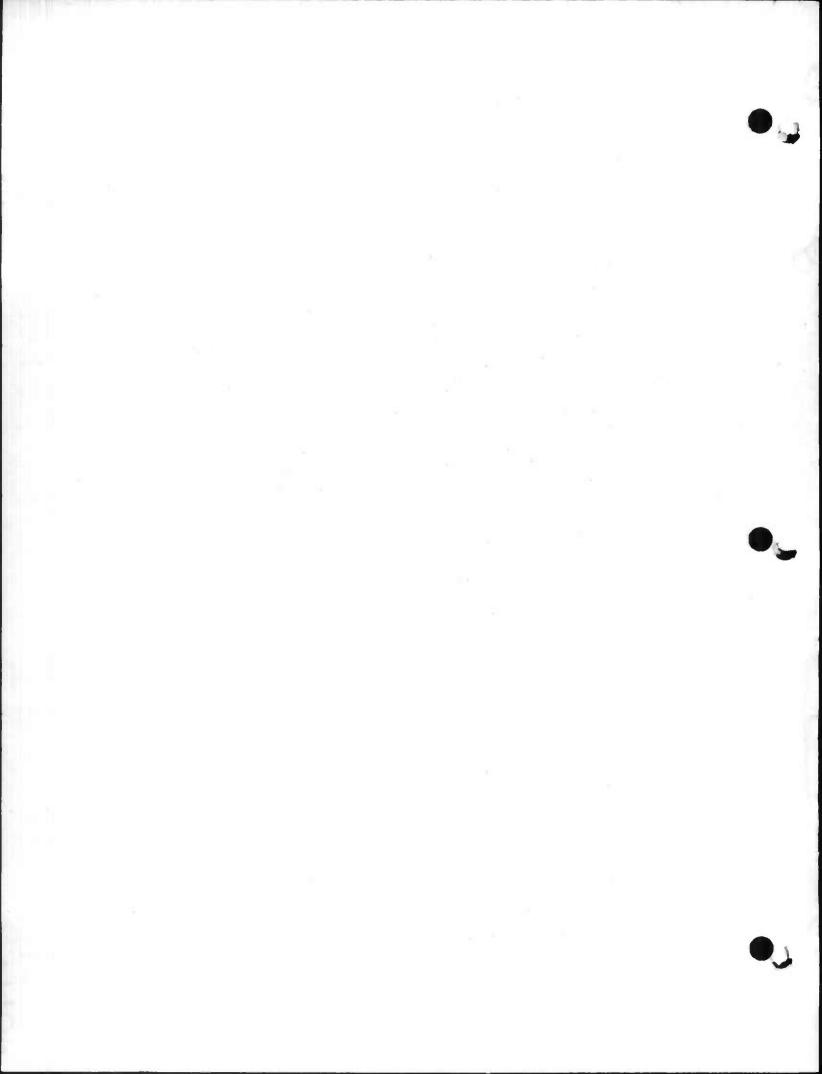
01.12.1999

20852

interval Between

Onsat and Death

Approximate



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death **Physician** Bernard Lawrence 0958 tan 1999 5 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Silve (Spying ar If Under 24 Hrs 8. Date of Birth (Month, Day, Examiner montzomery rentwood 6. Sax 1 XM 2 ☐ F ff Undar 1 Year | If Undar 24 Hrs 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) **Funerai** Days 102-20-4953 Yrs. Director 72 Usuai Rasidance of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ahow 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Monical Experient must be notified at 1 Yas 2 No Director MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? death with 902 BRENTWOOD LANE 20902 USA Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yas ≥ 2 No If Yas, Giva Yaar or Datas: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. should be filed within 72 hours after of Mental Hygiene. marked other than "natural", or ite 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) MANAGER DECORATING permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: If Itam 27 ia marked othe any Injury or other traumatic event. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) BENJAMIN POST 2 FANNIE FREEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) VILMA POST / WIFE 902 BRENTWOOD LANE, SILVER SPRING, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Locetion - City or Town, Stata 1 Buriel 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) JUDEAN MEMORIAL GARDENS 1/17/99 OLNEY, MD 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, DANIEL SIMONS 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Batween Onsat and Death **Physician** /Medical Immadiata Cause (Finel disaasa or condition rasulting in daath) **Examiner** Examiner The law requires that the death certificate be executed physician end s the buriel-transit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initioted avants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) Pert It. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco uss contributs to the cause of death? signed by the 1 Yss 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to complation of ceusa of death? 24a. Was an autopsy performed? Be Completed peed 1 ☐ Yas 2 ☐ No certificate 25. Was cese rafarred to medicel 26. Place of Death (Check only one) Othar: 4 ☐ Nursing Homa 5 ☐ RasIdance 6 ☐ Othar (Specify) Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 Yas 2 No 2 Accidant Invastigation 6 Could not be determined 3 Suicida 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida 29a. Cartifier 1 Certifying Physician: To the best of my knowladga, daath occurred at tha time, dete end plece, end due to the cause(s) and mannar as statad. Medical (Check only Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

Box 68760 Division of Vital Records, P.O.

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

State Registrar

31. Data filed (Month, Day, Year) JAN 19 1999

N.

29b. Signatura and titla of certifiar

BRECKER, MO DME 32 Registrer's Signetura

30. Name and address of person who completed causa of death (Item 23e) (Type, Print)

er m DME

Bilver Spring,

29c. Licansa number

D00428

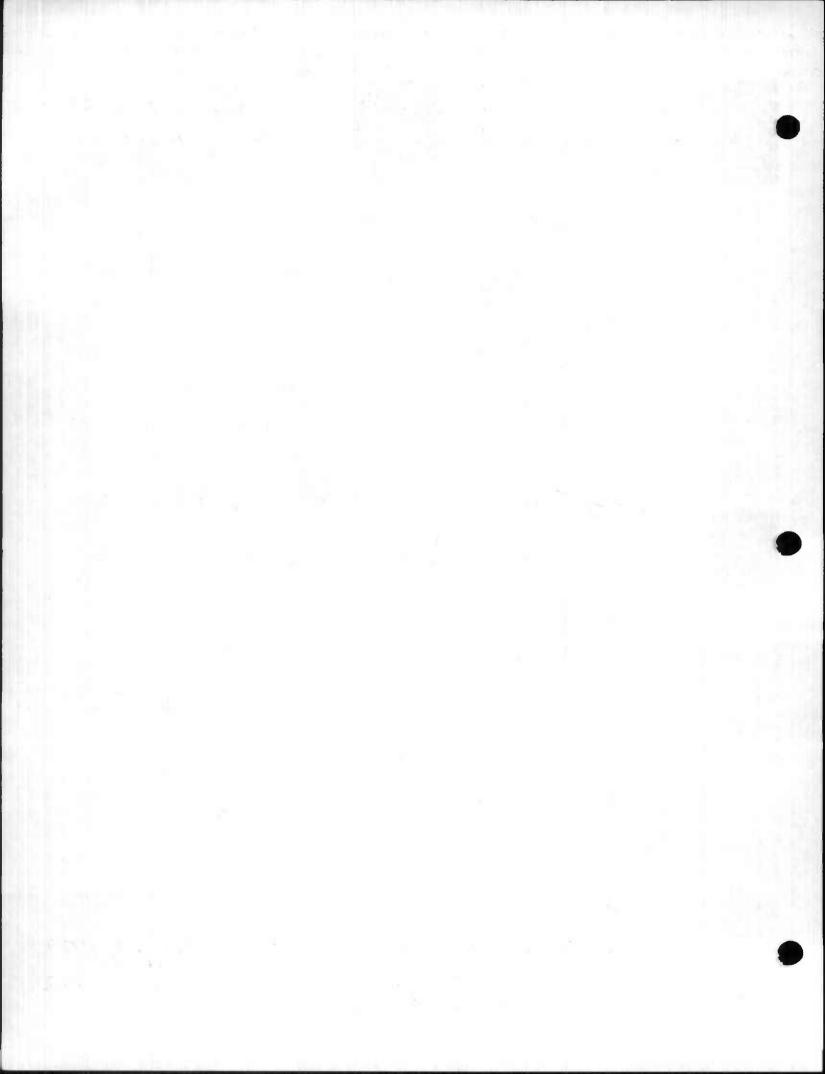
2101 medical Park

29d. Data signed (Month, Day, Year)

15, 1999

20902

10



State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death Month 3. Time of Death PETERS IRENE JANUARY 12, 1999 **ANNA** 8:30 A.M. 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death

/Medical Examiner

Physician

		GARRE'I'I' COUN'I'Y ME	MORIAL	HOSPITA	AL		OAKLAN	D	GARE	(EIT
Funeral Director		213-03-4033	x □ M 2 F	7. Aga (In yrs. I 82	est birthday) Yrs.	If Under 1 Yaar Months Days	If Under 24 Hi Hours Mi		birth (Pear) 1916	Birthplaca (State or Foreign Country) MARY LAND
2		Usual Residence of Decedent								
a-f show	stor	MARYLAND GARRETT			KLAND	eation				10d. Inside City Limits 1 ☐ Yas 2 No
23a or 28 at be no	ai Director	10e. Street and Number 1113 MARY DRIVE				10f. Zip Code	21550		10g. Citizen o UNITED	f What Country? STATES
"natural", or flems 23s or 28a-f show	by Funeral	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Giva Yaar or Da	ces? 2 No		Vas Decedent of Yas, specify Cub ☐ Yas 2 No	dispanic Origin? (an, Mexican, Pue Specify:	(Specify Yas or Norto Rican, atc.)	lo- 14. Re Bi	aca - American Indian, ack, Whita, atc. ify: WHITE
ene. then "nature he Madical E	Completed	15. Decedent's Edu (Specify only highest gred Elementery/Secondary (0-12)	cation le com <i>pleted)</i> College (1-	4or 5+)	(Give k	ent's Usual Occu ind of work dona O NOT use retire LERK	pation during most of w d)	rorking	16b. Kind of DRUG	Business/Industry
other	ပိ	17. Father's Name (First, Middle, Last)					19. Mathada N	omo /First Midd		
d d	Be c	PHILLIP	ਜ਼ ਹਵਾਧਾ	FDC			IRE	eme (First, Middle CNTC M	ACKIN	ine/
marked matic e	L P	19a. Informent's Name/Relationship (T)		EIVO	10h Mailin	a Address (Otros				0112
27 Is m		GEORGE J. KREIT /		Т		RICKELL		TANEYTO		n, State, Zip Code)
5 5		20a. Method of Disposition	COOSIN	20b. PI	ece of Dispos	ition (Name of		Date		a - City or Town, State
O C		1 Burial 2 ☐ Cramation 3 ☐ F		tate	metery, cram	etory or other ple		JAN 16,		
ngul,		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	1	EMM		`	CEMETERY	1		NSTER, MARYLAND
Important: If it any injury or o		John M. D	liles	M005		Nama and Address		SKILES STREET	FUNERAL TANEYTY	HOME OWN, MD. 21787
ed by the attending physician and detached for use as the buriel-transit are	Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last		Due to (or		c cardi	accid ovascu		sease	4 days
the a	/sic	Part tl. Other significant conditions con	ntributing to dea	th but not rasu	Iting In the un-	derlying cause gi	ven In Pert f.	23b. Dlo	tobacco use c	ontribute to the cause of death?
signed by	by Phy	chronic schi	zophre	nia				- 10	Yee 27 No	3 Probably 4 ☐ Unknow
noqu	Completed		9 8 44					24a. Wa per	s an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?
pag.	S							1□	Yes X 🗆 No	1 ☐ Yes 2 No
this certificate hes trained director, page 2 s	Be	25. Was case referred to medical examiner?	donnitel					eath (Check only	one)	
9 9	2	1 162 5V 140	lospital: 1 💆 Ing		R/Outpatient	3LI UUA		Home 5 □ Res		
I Director: After t d in by the funera	Certification:	27. Menner of Death 1 Netural 5 Pending 2 Accident Investigation	28e. Dete of (Month)	Dey Year)	28b. Time of Injury	28c. Inju Wo M 1	ryat rk? Yes 2 □ No	28d. Describe	how Injury occu	urred
Direct	Sertific	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place o building	f Injury - At hor g, etc. (Specify)	me, farm, stre	et, factory, offica		28f. Location City or To	(Street end Num own, Stete)	nber or Rural Route Number,
To the Funeral Dire completely filled in b	edicai (29a. Certifier (Check only one) 12 Certifying Physical Examination (Check only one) 12 Medical Examination (Check only one)	sician: To the b nar: On the bas and manne	is of examination	rledge, deeth on and/or inve	occurred at the ti estigation, in my o	me, date and pled opinion, death occ	ce, end due to the curred at the time	e cause(s) end n	nanner as steted. , and dua to the cause(s)
To th	Me	29b. Signature and title of certifier	RI	45	2	29c. Licens			29d. Data sign	ed (Month, Dey, Year)
ı		30. Name and address of person who co	mpleted ceuse	of death (Item	23a) (Type, P					

Donald R. Richter M.D. 1533 Memorial DR Oakland, MD 21550

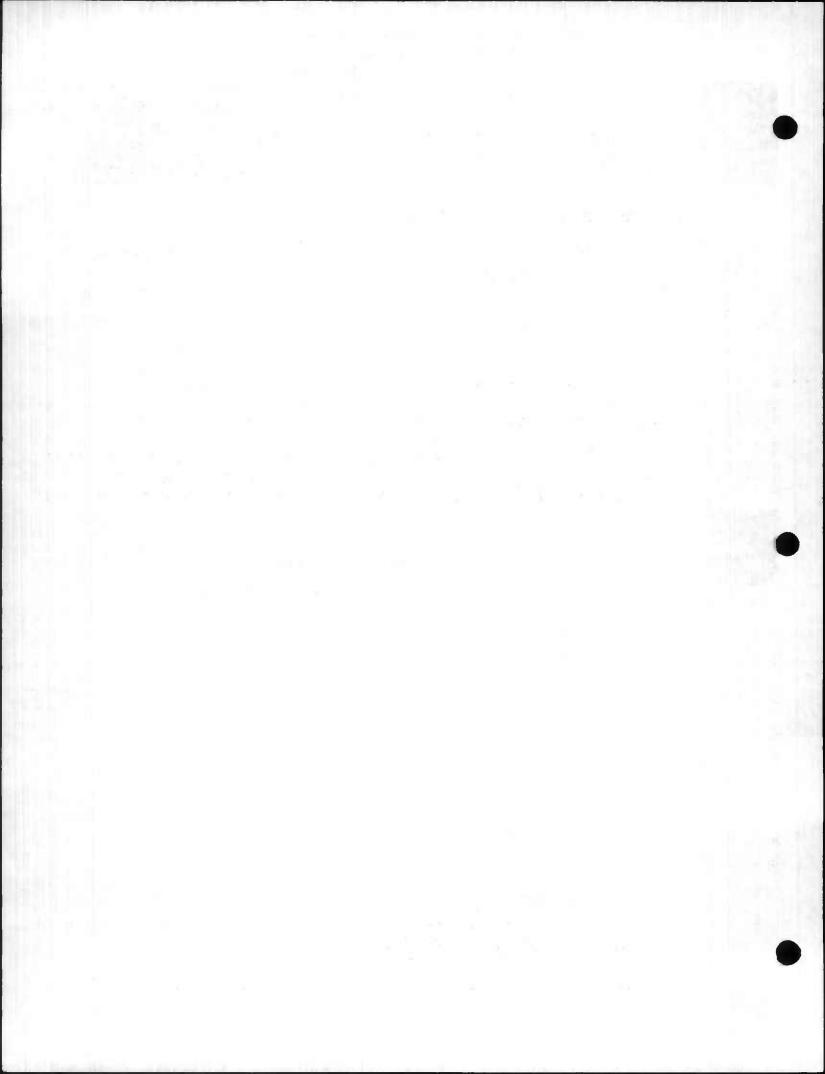
32. Registrar's Signature

State

Registrar

31. Date filed (Month, Day, Yeer)

JAN 1 9 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Red No. 1. Decedant's Name (First, Middla, Last) 2. Data of Death Day Year Month 3:00 AM Nellie M. Price January 1999 14 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2231 Pelham Ave. N/A Baltimore If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Months 1 M 2 XF Yrs. 216-14-5299 85 Sept. 10, 1913 West Virginia Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ¥Yas 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21213 United States 2231 Pelham Ave. 12. Was Decedent Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black White etc. 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Businass/industry 15. Decedant's Education (Specify only highast grada complated) 18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) College (1-4or 5+) Elementery/Secondary (0-12) own home 12th homemaker 18. Mother's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Frank Bernard Bell Mary Frances Milton 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Olivia Whittemore 2231 Pelham Ave. Baltimore, MD Daughter 21213 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, State 20a Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Donation 5 Othar (Specify) Taylorsville Ch. Cemetery 1/18/99 Taylorsville, MD 21. Synature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Burrier-Queen Funeral Directors, P.A. 23a. Part1. Enter the disease, or complessions that caused the country. Do not anter the mode of dying, such as cardiac or raspiretory errest. Approximate shock, or heart failure. List only one country shock in the mode of dying, such as cardiac or raspiretory errest. Approximate Interval Between Onsal end Deeth Imm ediata Causa (Final July 1 se or condition resulting in death) 10 mim Heart cars Saquantially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Disaasa or Injury Dua to (or as a consequence of): that initiated evants rasulting in daath) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ÛNO 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of cause 24a. Wes an eutopsy performed? of death? 1 Yas 2 No 1 Yes 2FTNo

Physician /Medica! Examiner

certificate be axec

Records,

Division of Vital

Physician

/Medical

Examiner

10a. Stata

Funeral

Director

r 28a-f show

ir than "naturel", or items 23s or

d 2 should be filed within 72 hours after death the nd Mental Hygiene.
7 ie marked other than "naturel", or itema 23. tranmatic event, the Medical Examination must

Pages 1 end 2 sinent of Health en

6 Department of Important: If any Injury or once.

with

Directo

Funeral

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Completed

Be

Examiner physician end the burial-trensit 88 use a signed by the a page 2 s funeral

P Certification:

cartificate

Affer

24 hours after death.

within 2 4

completaly

or Attending

Hospital

0

Physician/Medical þ Completed

25. Was case referred to medical 1 Yas 2 No

27. Mannar of Death 1 Natural 5 ☐ Panding 2 Accident

3 ☐ Suicide 4 Homicida

29a. Cartifiar

(Check only one)

28a. Data of Injury (Month, Day Year) investigation

6 Could not be datarmined 28e. Plece of Injury - At home, farm, streat, fectory, offica building, atc. (Spacify)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yas 2 ☐ No

26. Placa of Death (Check only ona)

28d. Dascribe how Injury occurred

Location (Street and Number or Rural Routa Number, City or Town, Stata)

29b. Signatura and titla of certifian

M.D.

29c. Licansa number 052016 29d, Data signed (Month, Day, Year)

30. Name end eddrass of persen who completed cause of deeth (Item 23a) (Type, Print) Calvert St. #520, Baltimole, MDanie 3333 N.

ramara

Waiel Jamara, 31. Data filad (Month, Day, Year)

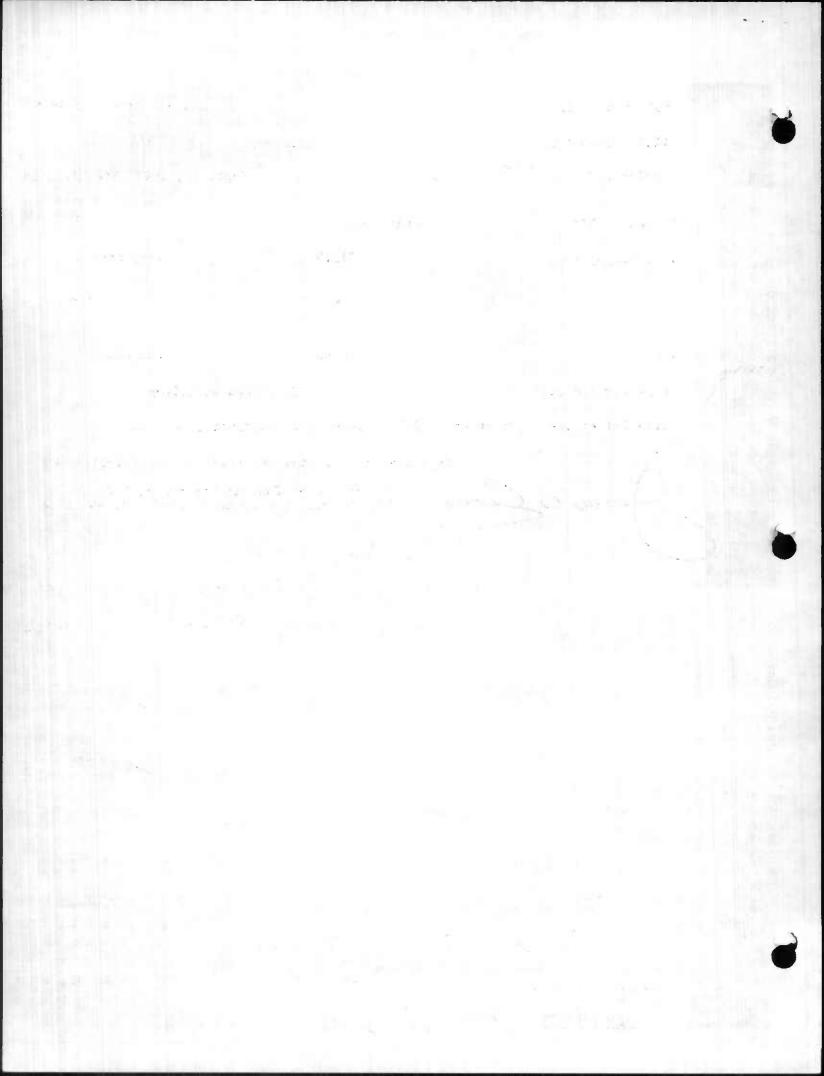
1 9 1999

32. Registrar's Signatura

1 Cartifying Physician: To the best of my knowledge, daeth occurred at tha time, data and place, and due to the ceuse(s) and mennar as steted.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stelled.

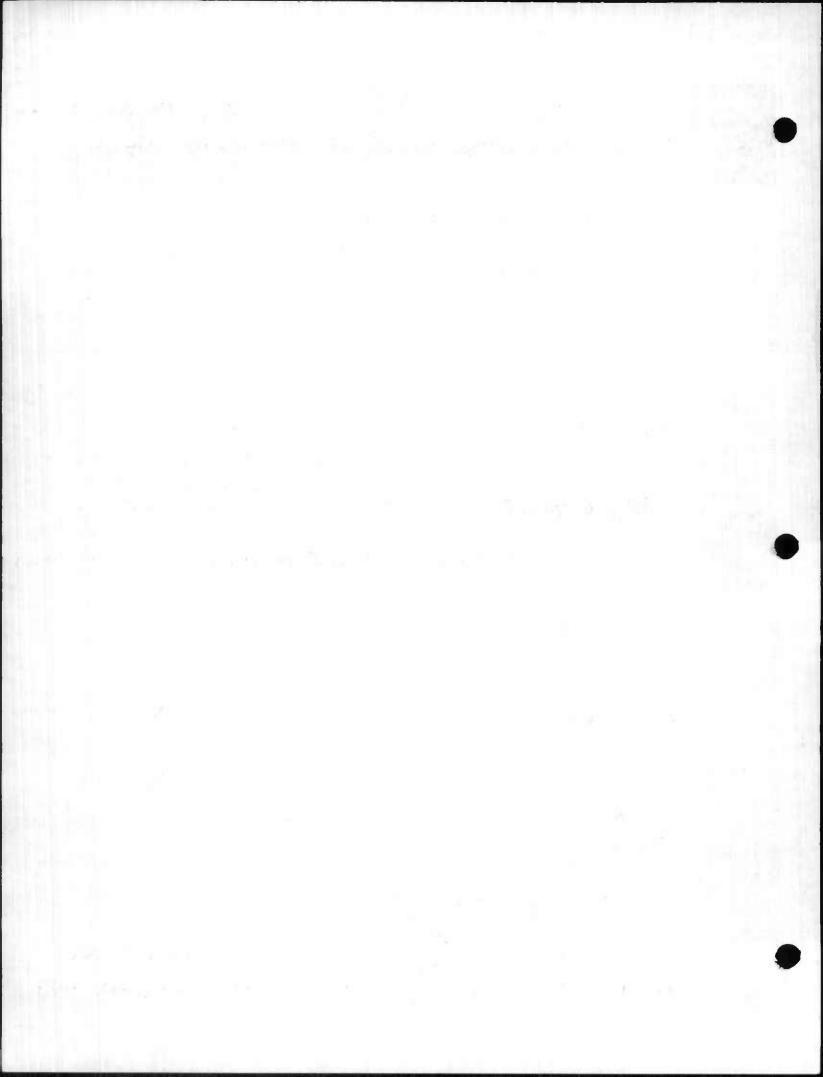
State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 18th 1999 4e. Fecility Neme (If not institution, give street end number) Jan 5110 Mun /Medicai 4h City Town or Location of Deeth 4c. County of Deeth **Examiner** Months Months Carroll Lughern Village Nursing Sacurity Number 6. Sex 7. Age (In yrs. lest birthdey) Hame Westminister Coursy 8. Date of Birth (Month, Dey, Year) if Under 24 Hrs. 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** 1□M 2XF Deys 218 14 2935 87 Director Maryland May 13, 1911 Usuel Residence of Decedent the Merylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or itema 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at Carroll Westminster 1 Yes 2 No Director Md. 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? with 201 St. Mark Way 21158 U.S.A. Funeral Wes Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 72 hours efter 1 ☐ Yes 2 🗷 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within it Depertment of Health end Mentel Hygiene Important: if item 27 is marked other than any injury or other traumatic and any other traumatic and any other traumatic and any other traumatic and any oth Social Security Elementary/Secondary (0-12) College (1-4or 5+) Secretary Administration 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Edward Koenig Dorothea VOlz 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Doris Ann Heinlein (daughter) 17224 Grace Rd. Hampstead, Md. 21074 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20e. Melhod of Disposition 20c. Location - City or Town, Stete 1 Dauriel 2 Cremetion 3 Removel from State Lake View Mem. Park 1/20/99 Sykesville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Sykesville, Md. 21784 23a. Pent 1. Enler the disease, or complications that caused the shock, or high failure. List only one cause on each line. Haight Funeral Home & Chapel P.O.Box 195 lions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset end Death **Physician** /Medicai Immediate Cause (Final Acute Muscurelval Infanction
Due to (or sea Donsequence of): Few Hours disease or condition resulting in death) Examiner Examiner buriel-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last end Due to (or es e consequence of): physician sthe buriel Box 68760. Physician/Medical Due to (or as e consequenca of) esn ō signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2/No 3 Probably 4 ☐ Unknown Mixed Demintic à 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen hes page 2 certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours efter deeth.
 Funeral Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ZNO 2 funeral 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Phyalctan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examination on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signeture end title of ce 29c. License number 29d. Dete signed (Month, Dey, Year) Jan. 18+41999 1)37949 30. Name end eddress of person use of deeth (1 (Type, Print) Alexander Ponder scheniste 31. Date filed (Month, Dey, Year) 32. Regis , weschinister, MD, 21157 205 32. Registrar's Signeture to Mainte Win State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Yaar Ralph Plummer Sr. 0445 4b. City, Town, or Location of Death 19 1999 4a. Facility Nama (If not institution, giva straat and number) 4c. County of Death The Kent & Oueen Anne's Hospital Inc. Chestertown Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 10, 5. Social Security Number 6. Sax XXM 2□ F 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Year 1920 Townsend, DE 219-07-5020 78 Yrs. Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Maryland Kent Chestertown 10a. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 24476 Chestertown Road 21620 USA 12. Wes Decadant Evar in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, White, etc. 1 Navar Married 2 Married 1 □ Yas Z\Q\No If Yas, Giva Yeer or Dates: 1 ☐ Yas 2 No Specify: White 3 Widowed 4 Divorcad 15. Dacadant's Education (Spacify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) Tax Assissment Officer Kent Co. Government 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Malden Sumama) George W. Plummer Ada Auston 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Doris Smith Plummer/Wife 24476 Chestertown Road, Chestertown, MD 21620 20b. Piaca of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) Chester Cemetery 1/22/99 Chestertown, Maryland 22. Nama and Addrass of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD Do not antar tha moda of dying, such es cardiec or respiretory arrest, Approximate Interval Between Onsat end Death Immediata Causa (Final ACUTE 6-1- BUETONI. disaesa or condition rasulting in death) FMCLUCE REMAR Saquentielly list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting In death) Last Due to (or as a consaquenca of): Due to (or as e consaquanca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Department of Important: If any injury or

Physician

/Medical

Examiner

Funeral

Director

show

rai', or items 23a or 28a-f shore

"natural", or

Hygiene.

.. Pegas 1 and 2 should be filed w tment of Health end Mental Hygien tant: If item 27 is marked other ti jury or other traumatic event, tr

the Medical

Directo

Funerai

by

Completed

Be

the Maryland

filed within 72 hours efter death

21215-0020

Baltimore, Maryland

Attanding Physician: The law requires that the death certificate be executed the filled in by the funeral or Attand after deeth Director:

Division of Vital Records, P.O. Box 68760.

Examiner Physician/Medical à Completed Be Certification: To To the Hospital o within 24 hours af To the Funeral Di completaly filled in

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27

Medicai

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				24a. Was an autopsy parformad?	24b. Wara autopsy findings aveilable prior to complation of cause of death? 1 Yas 2 No
Was case rafarrad to medical axeminar?			26. Pleca of D	Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatiant 2	☐ ER/Outpatiant 3☐ I	DOA Other: 4 Nursing	g Homa 5 ☐ Residence 6 ☐ Oth	nar (Specify)
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3 Sulcida 6 Could not datarmined			ory, offica	28f. Location (Street and Numb City or Town, Stata)	ber or Rural Routa Number,
a. Cartifiar (Check only one) (Check only one)	hysician: To the bast of my kni minar: On the basis of axamin and mennar stated.	owledga, daath occurre atlon and/or invastigation	ed et tha tima, data and pla on, in my opinion, daath oo	ace, and dua to the causa(s) and moccurred at the time, date and plece,	ennar as stated. and dua to tha ceusa(s)

29b. Signature end title of cartifier

17-138-24

29c. License number

29d. Date signed (Month, Day, Year)

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

John C. Seymour 122 Speer Road, Suite 5, Chestertown, MD 21620 31. Date filed (Month, Dey, Year)

State Registrar



S. Spark

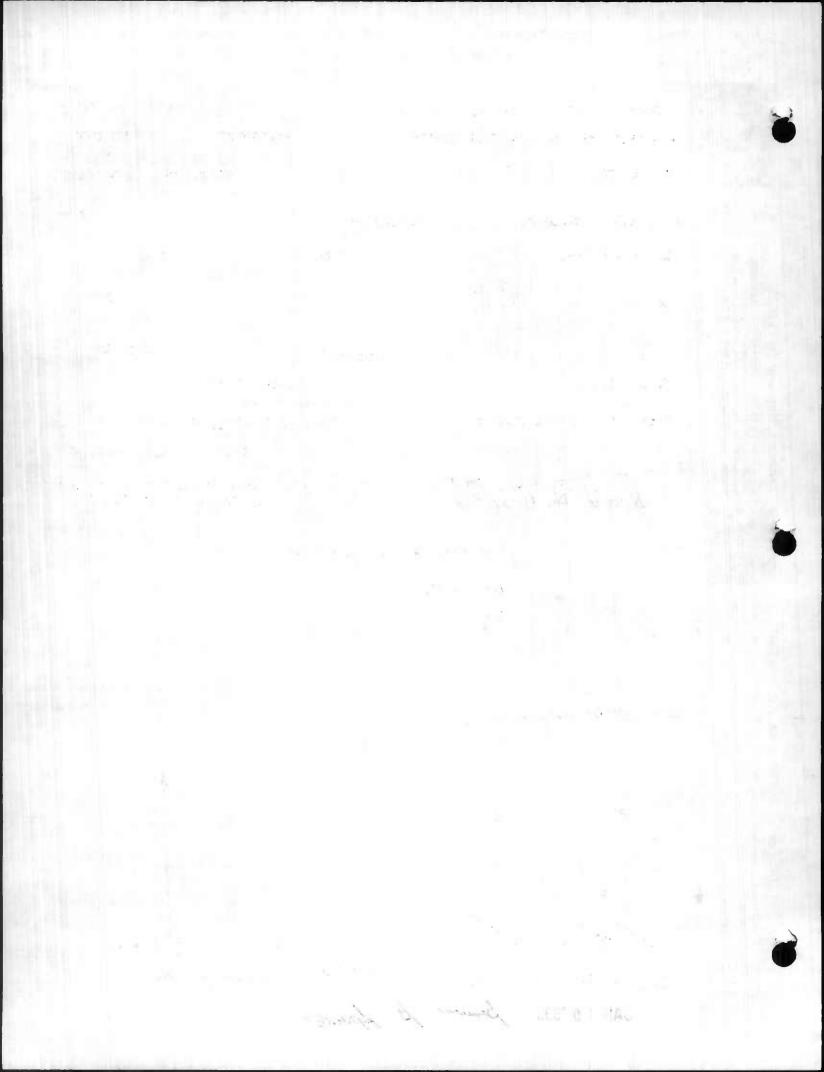
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State of Maryland / Department of Health and Mental Hygiene Q Q

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) Month **Physician** 1999 January WHITE INSLEY PURNELL /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dev. Year) Birthplaca (Stete or Foreign Country) **Funeral** Days 1 M 25 F Yrs. 217-44-2208 **Director** Maryland Usuat Residence of Deceden with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Madical Examiner must be notified at ty Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 808 Alvin Ave. 21804 USA 2 should be filed within 72 hours after death in and Mantal Hygiane.
Is marked other than "netural", or items 23 Funeral Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0020 Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Domestic 12 Housewife 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) F. Lee Inslev Pauline White 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) permit. Pagas 1 and 2 st Department of Haalth and Important: If Item 27 is n Herman L. Purnell III/Son 808 Alvin Ave., SAlisbury, MD 21804 Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or o 1/18/99 Salisbury, MD Parsons Cemetery 22. Name and Address of Facility M01051 Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Intervel Between Onset and Deeth **Physician** tmmediate Ceuse (Final disease or condition resulting to deeth) /Medical nespiratory Examiner Examiner menone. physician and the burial-transit daath certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in deeth) Lest Due to (or as e consequenca of) Physician/Medicai Due to (or es e consequence of) 88 use a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2 No 3 Probably 4 Unknown encepholomalas. þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed paga 2 cartificata has 1 TYes 2 □ No 25. Was case referred to medical examiner? Be 26. Ptece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 tnpatient 2 ER/Outpatient 3 DOA 10 Aftar this funaral 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. tnjury et Work? Certification: Division 5 Pending investigation Reture aftar daath. **Q** □ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifie (Check only one) within 2 \$ 29b. Signeture and title of 29c. License number 29d. Dete signed (Month, Dev. Year) 30. Name end address of person who completed cause of death (Ijem 23a) (Type, Print) n w , Nado 31. Dete filed (Month, Day, Year) 32. Registrar's Signature JAN 1 9 1999 Registrar

Jane Punnel



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2 Date of Deeth 3. Time of Deeth 1. Decedent'e Neme (First, Middle, Last) Month

JONUAU 1 9 1 1 Month **Physician** 12,1999 MILDRED RICHARDS PARKS /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner SALISBURY
If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Yeer) PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign Country) **Funeral** 1□ M 2 F Months Deys Yrs. Director 213-60-9166 94 Virginia Usual Residence of Decedent the Meryland 10d. Inside City Limits 10e. State 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Merylan Department of Health end Mentel Hygiene. Important: If item 27 is merked other than "naturel", or items 23e or 28s-f show any injury or other traumstic svent, tre Medical Examines front the notified as 1X Yes 2 □ No Director Salisbury Wicomico 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 420 Pinehurst Ave. Funeral 21801 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 SNo If Yes, Give Yeer or Detes: 14. Rece - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 X Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Homemaking 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Ann Johnson John J. Richards 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Howard R. Parks 3351 Stone Rd., Cape Charles, Va. 23310 20b. Plece of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion Other (Specify) 1/15/99 Belle Haven, Va. Belle Haven Cemetery 22. Name and Address of Facility
Doughty Funeral Home, Inc. Service Licenses Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. P.O. Box 633, Exmore, Va. 23350 Approximete Interval Between Onset and Deeth Physician tmmediete Cause (Finel diseese or condition resulting in death) /Medical Circulatory Examiner Due to (or es e consequence of): Examiner burial-trensit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest and Due to (or es e consequence of): physician s the burial Box 68760, Physician/Medicai Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yss 2 No 3 Probably 4 Unknown alerioschrotic þ 24b. Were eutopsy findings evaileble prior to completion of cause of death? Completed 24e. Was en eutopsy performed? peen 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 28c. Injury at Work? 27. Menner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of ol or Attending F after death. Director: After After 1 Neturel 5 Pending 1 Tes 2 No investigetion 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, term, street, fectory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 29e. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, end due to the cause(s) end menner stated. Medical

Registrar

31. Dete filed (Month, Dey, Year) JAN 1 9 1999

oomen

29b. Signature and title of certifier

32. Registrar's Signeture

aw enrich

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

RODNEY A. WENRICH, 100 PO 100 POWER ST.

29c. License number

15384

SALISBURY

29d. Date signed (Month, Dey, Year)

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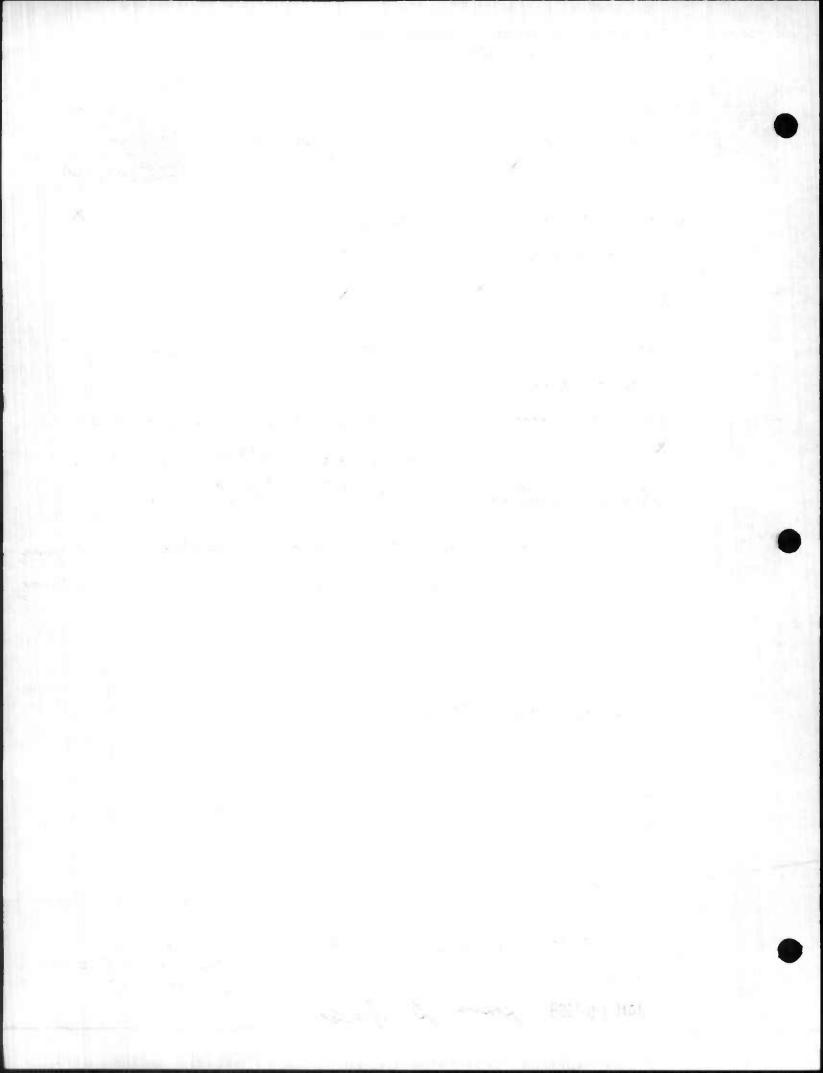
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State of Maryland / Department of Health and Mental Hygiene

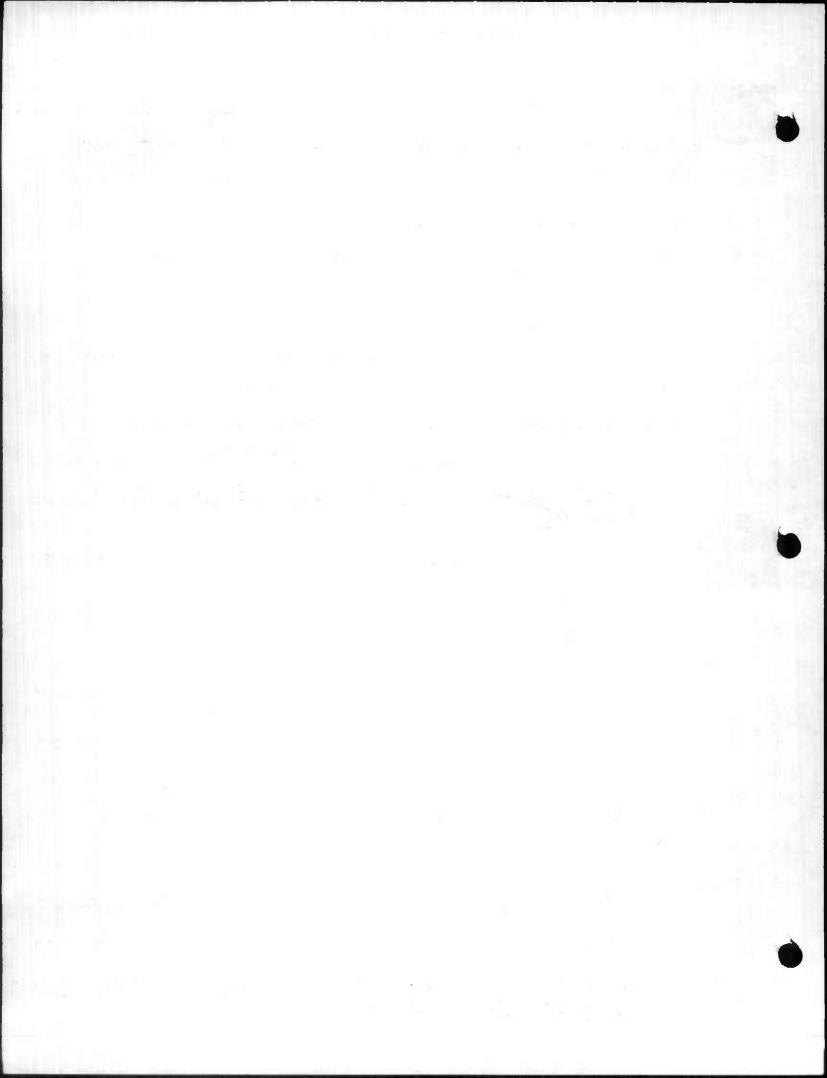
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	Dharaia		Decedent'e Neme (First, Middle, Last)			2. Date of Dee Month				. Time of Deeth
	Physic /Medi		Thelma Downing Parker			Jan.	14	1999		907
	Exami		4e. Fecility Neme (If not institution, give street and number)		4b. City, Town, or	Location of Deeth	4	c. County of D	eeth	1.0
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	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Months 1 Usuel Residence of Decedent	Deys			Year 0 1	9.1 1905 Ma	Country)	e (State or Foreign and
	puel Man		10e. Stete 10b. County 10c. City, Town or Location						10d.	Inside City Limits
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	or 28a	Director		ip Code		1	0g. C	itizen of Whet	Country?	
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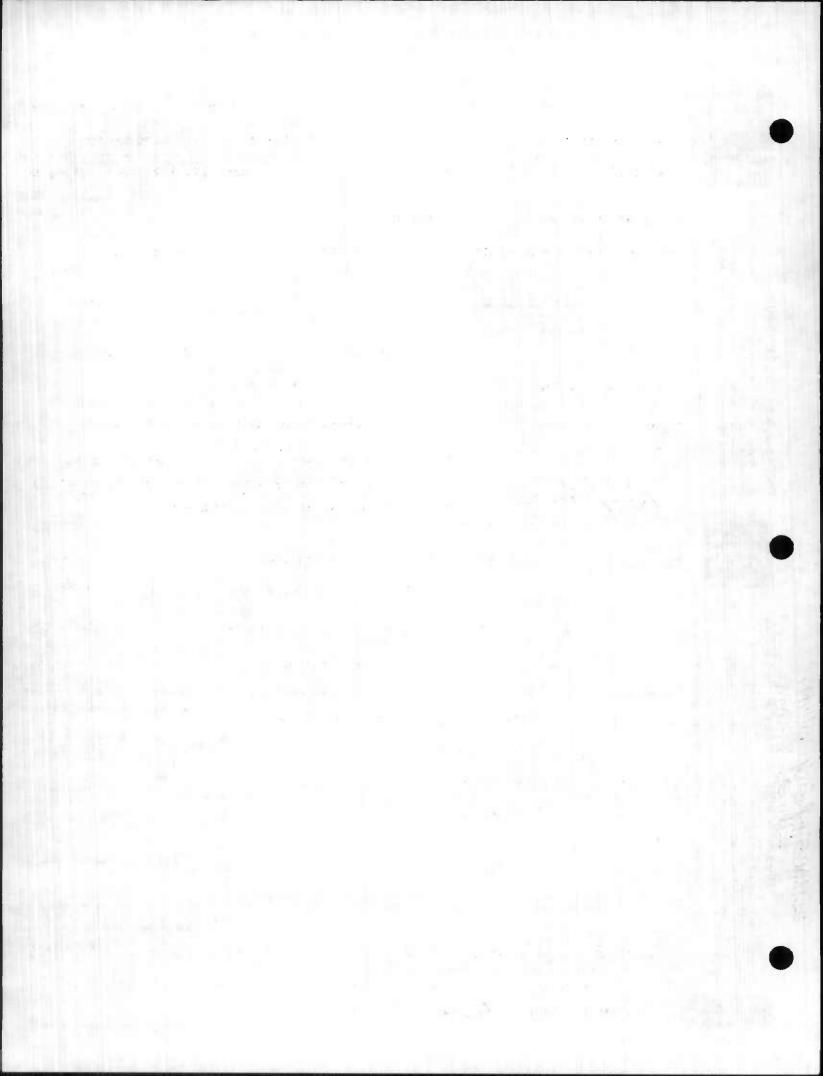
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aryla should t	Went rked rtic e	10	Harry Wendrich							Ju	lia	Muller			
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Baltimore,	nent of Health a ant: If item 27 is ury or other tra		20a. Method of Disposition		20b.	Plece of	Dispos	ition (Ner	ne of	ce) T_	1	Dete	20c. Location -	City or Town	, State
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5	Dire	ert	4 Homicide	buildir	ng, etc. (Speci	ify)						City or To	wn, State)		
Hospital	ours Merai		29a. Certifier (Certifying Ph	vsician: To the	best of my kno	owledge.	death	occurred	at the tir	me, date ar	nd place.	and due to the	cause(s) and ma	nner as state	ed.
Ho	within 24 hours a To the Funeral D completely filled i	edicai	(Check only 2 Medical Exar	niner: On the ba	asis of examination	ation and	or Inv	estigation	, in my o	ppinion, dea	th occurr	ed at the time,	date and place,	and due to th	ne cause(s)
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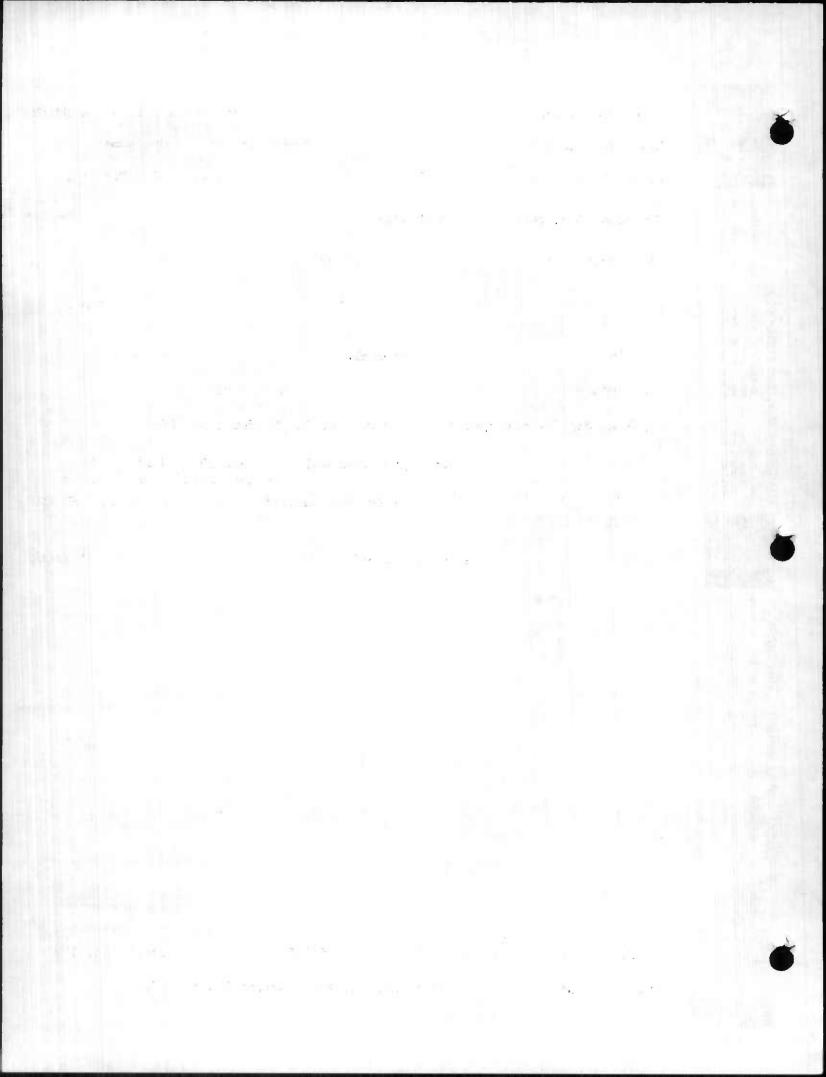
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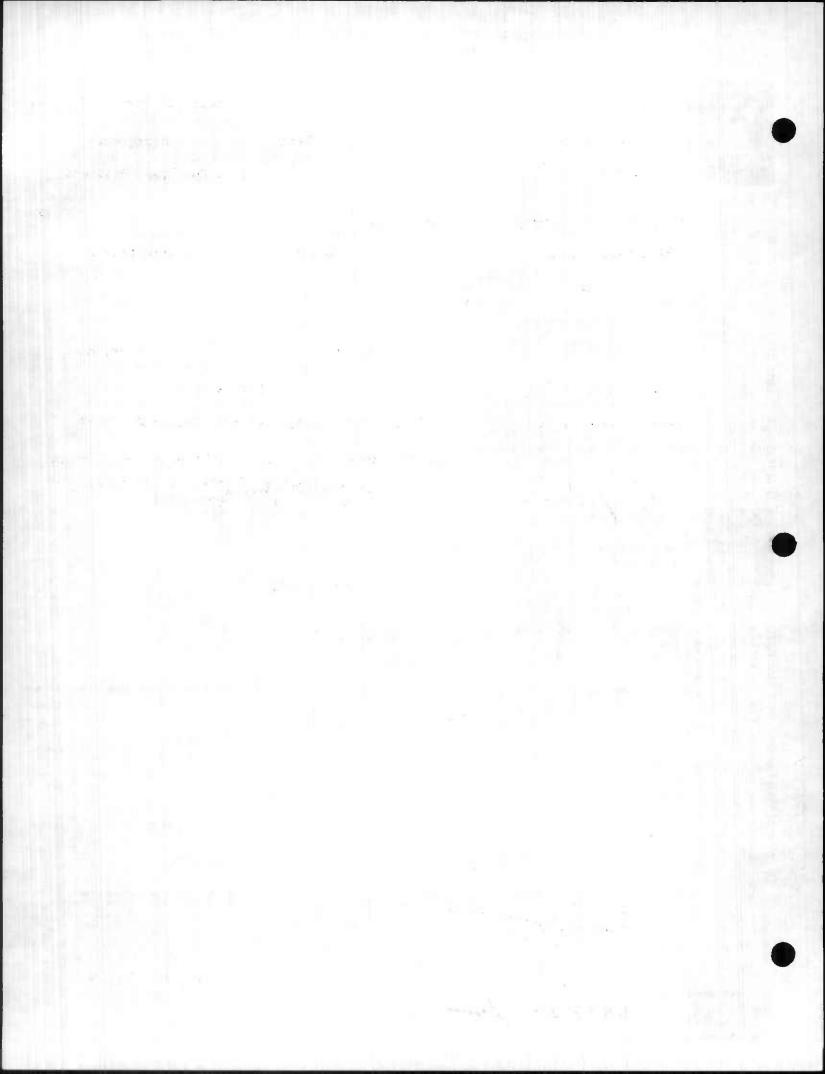


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or 28	106	. Street and Number				10f. Zip	p Code			10g. Citizen of	What Cou	ntry?
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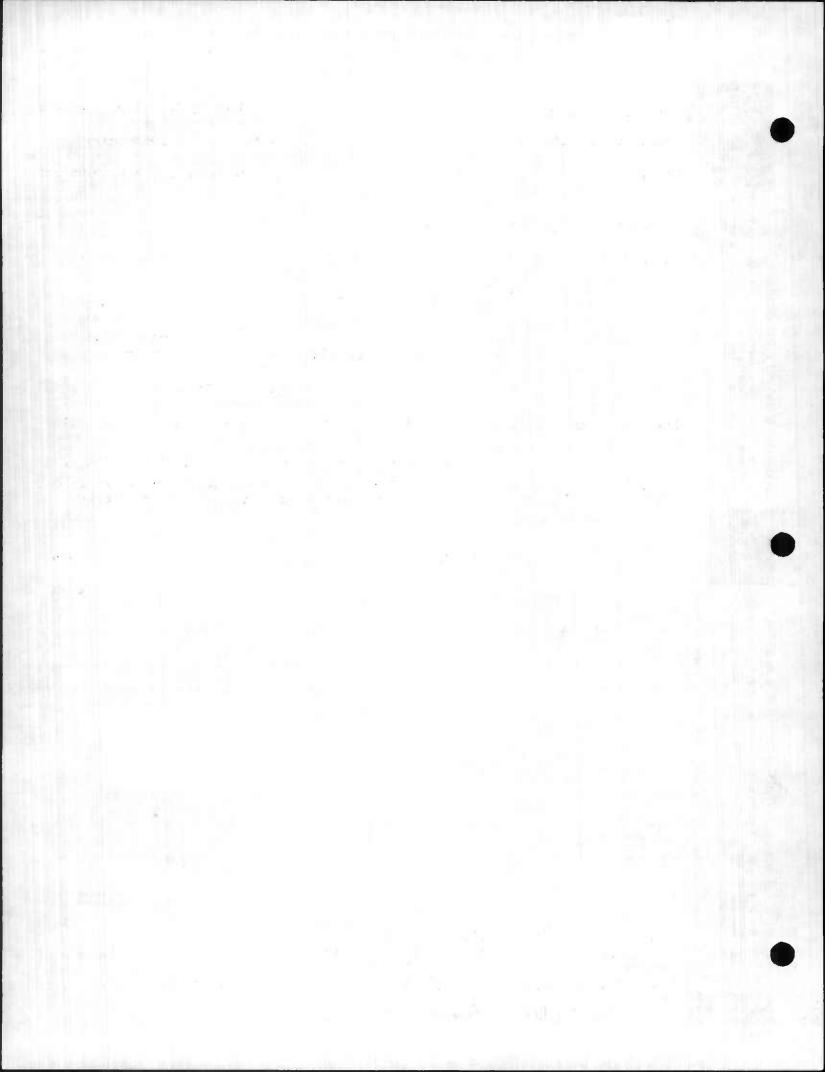
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18. Mother's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Medicine Sumame)		(Specify	ducation de completed)	cation 16a. [Decedent's Usual Occupation (Give kind of work done during most of working			16b. Kind of Business/Industry				
Andrew Edwin Riley 19a. Informant's Name (First, Middle, Meiclen Sumame) 19a. Informant's Name Relationship (Typa, Print) 19a. Informant's NameRelationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 19a. Informant's NameRelationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 10b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 10b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 10b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 10b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 10b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 10b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 10b. Mailing Address (Street and Number or Rural Route Number. City or Town, Stete, Zip Code) 10b. Mailing Address (Street and August Andress (Street and Number or Rural Route Number. City or Town, Stete) 10b. Mailing Address (Street and Number or Rural Route Number or Rural Route Number. City or Tow	Elementary/Secondary (0-12) College (1-4or 5					+)								
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contribute to the cause of the caus	physician and the burial-transit the conference dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):												
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25. Wes case referred to medical exeminer? 1 Yes Z No											av co	ailable prior to mpletion of cause		
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4 Homicide 268. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 299. Certifier (Check only 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated.	1 Naturel 5 Pen 2 Accident inve		5 Pending investigation	28a. Date (Mor		-	of 2				ribe how injury occurred			
(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s			6 Could not be determined	288. PIBC	e of Injury - At ting, etc. (Spe	home, farm, s	treet, factory	, office		28f. Location (City or To	Street and Numi wn, State)	ber or Rure	al Route Number,	
71117 755 //		29a. Certifier 1[(Check only 2[Certifying Ph Medical Exam	niner: On the b	pasis of exami	nowledge, dee nation and/or i	th occurred nvestigation,	at the ti	me, date and place opinion, death occ	a, and due to the urred at the time,	ceuse(s) and m date and pleca,	anner as s and due to	tated. the ceuse(s)	
1600 nome=2704 1/1/94	29b. Signature and title of certifier					29c. License numb			umber 29		id. Date signed (Month, Day, Year)			
0000 8 / / 7 1 / 7 / 1 / 7 / 7	1 /11/10				0				16052774		1/16/99			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)	30. Name and address of person who completed cause of death (Item 23e) (Type, Prin					, Print)		1.		1/10	1.1			



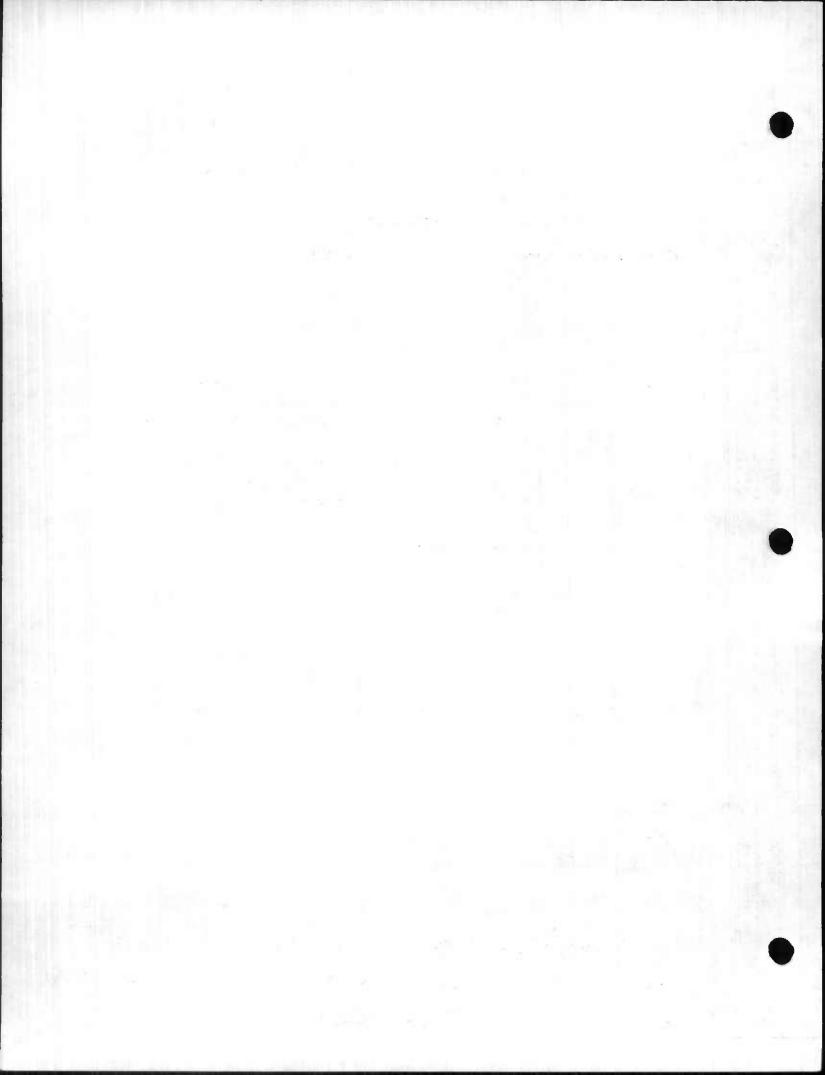
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	Decedent's Name (First, Middle, La	st)		rtificate of		2. Data of Deat	h No.	3.	Tima of Death
Physician						Month	Day	Year	. 10 DM
/Medical	Everett C. Romp 4a Facility Nama (If not institution, give				4b. City, Town, or L	January	18, 1		5:10 PM
Examiner		THE RESERVE TO SERVE							
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uneral rector	040-14-9753	M 2□F 82	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, September			(Stata or Foreign
adait or	Usuai Residenca of Decedent 10a. State 10b. County		City, Town or Lo	postion					nside City Limits
notified at									Yas 2 No
Director	Maryland Montgo	mery	Bethes	10f, Zip Code		10	Og. Citizen of V	Vhat Country?	
ā	5322 Pooks Hill	Dond		208	21 /		Unito	d State	0.0
Funeral	11. Maritai Status	12. Was Decedent Ever i	n U,S. 13.1		Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-	14. Rac	e - American in	
F	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give Wor		tf Yes, specity Cub 1 ☐ Yes 2 💆 No		o Rican, etc.)		k, White, etc.	
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Wor Year or Dales: War	II	1 LIYes ZKAINO	Specify:		Specify	White	2
Completed	15. Decedent's E	ducation da completed)	16a. Dece	dent's Usual Occu	pation during most of wor	king	16b. Kind of Bu	sinass/Industr	у
nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		United	States	5
S		5+	Educa	ational A			Govern	***************************************	
e B	17. Fathar's Nama (First, Middla, Last,				18. Mother's Nan	ne (First, Middle, A	Maiden Sumam	ie)	
2	Albert Rompf					e Stelzle			
	19a. Informant's Name/Relationship (Type, Print)			t and Number or Ru				
		wife			ill Road,				
	20a. Method of Disposition 1 ☐ Buriai 2 X Cremation 3 ☐		b. Place of Dispo cemetary, crar	matory or other pia	January 2	Date 2	20c. Location -	City or Town,	Stata
	4 ☐ Donation 5 ☐ Other (Specif		ontgome	ry Cremat	corium, I	nc.	Bethesd	a, Mary	yland
DUCE.	21. Signature of Funeral Service Licer	100	831	Alama and Adde			Rethesda	-Chevy C	hase. Inc.
8	Da-bara p 11/0	Mulundan			in Avenue,				
	23a. Part1. Enter the dispase, or com shock, or heart failure. List only	plications that caused the cone cause on each line.	leath. Do not ent	ter the mode of dy	ng, such as cardiac	or respiratory arre	ast,	App	proximate trval Batwaan
an								On	set and Death
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ier	resulting in death)	-	o (or as a consec	quence of):					
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edical	that initiated events rasulting in daath) Last	Due t	o (or as a consec	quence of):					
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cian/M								- 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10	
ysi	Part II. Other significant conditions of	ontributing to death but not	resulting In the u	inderlying cause gi	ven in Part I.		bacco use co ss 2⊠ No		cause of death?
Completed by Physician/M						1 Y	88 243 NO	3 Propabi	y 4 Unknow
ed by P						24a. Was a	n autopsy	24b. Ware a	autopsy findings ble prior to
Sieted						pertorr	neu r	comple of deat	etion of cause
Comp						1 □ Ye	s 2 X No	1 ☐ Ye	s 2 No
Be C	25. Was case referred to medical				26. Place of Date	ath (Check only on			
2	axaminer? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ inpatient	2 ER/Outpatle	nt 3 DOA		lome 5 ☐ Reside		ar (Specity)	
	27. Manner of Death	28a. Data of injury (Month, Day Yea	28b. Time o	f 28c. inju		28d. Describe ho			
catio	1 ØNaturai 5 ☐ Panding 2 ☐ Accidant invastigatio		Hijury		Yes 2 □ No				
title .	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Placa of Injury - / building, atc. (Sp	At home, farm, str	reet, factory, offica		28f. Location (St City or Town	reet and Numb	per or Rural Ro	oute Number,
Certification:		bulloning, atc. (Sp				J., J. 10W	,,		
Medical Certifi		ysician: To the best of my							
Pal Pal	one)	and manner stated.	mation and/or in			D.1111- CONT. 1			5.1111.57
	29b. Signature and title of certifier	1 100	Dr. 15	29c. Licen	se number	2	9d. Date signe	a (Month, Day	, TOM()
2+1	Talical	Tranco	This	D2	1392		January	19, 1	999
	30. Name and address of parson who		1						
	Patricia D. Kello	ogg, M.D. 86	Veirs	Mill Ro	ad, Rockv	ille, Ma	ryland	20851	
	31. Date filed (Month, Day, Year)	32. Ragistrar's S							



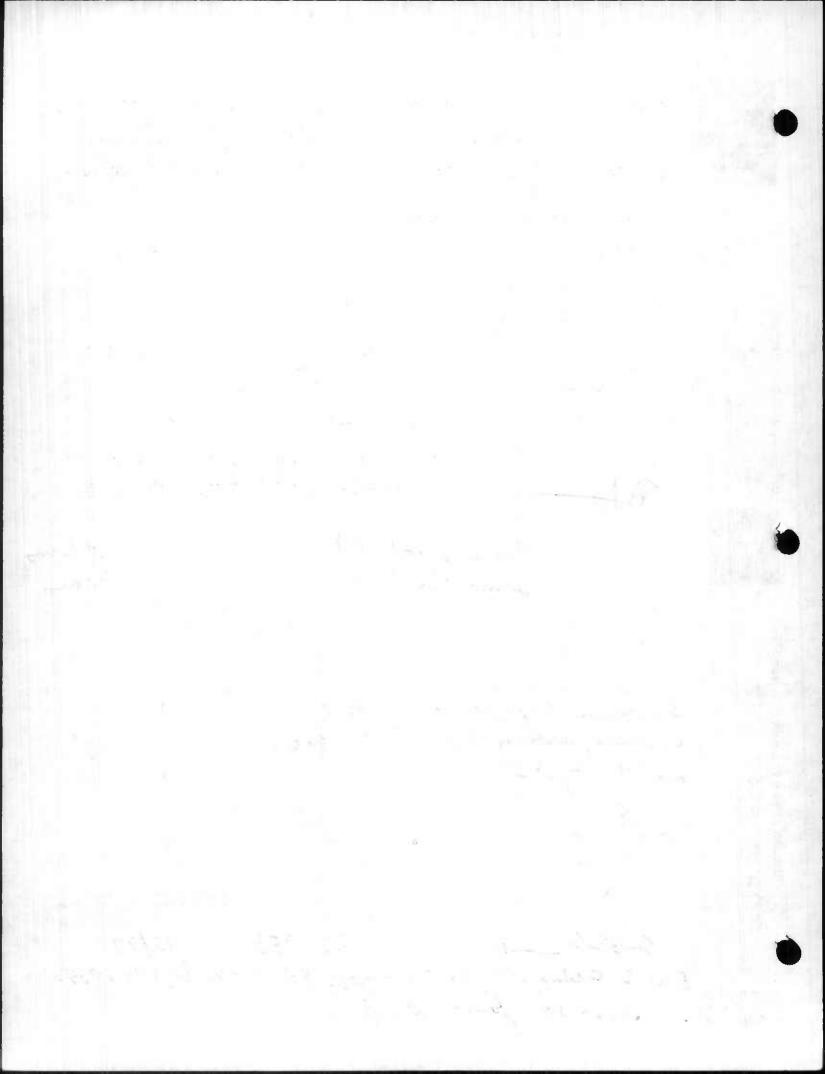
State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 6 4 6

			(Certificat	e of l	Death		Reg. No.	0 2 0 -8	0
	1. Decedent's Nema (First, Middle, Last)	# 11				2. Dete of De			/ Deeth
Physician /Medical	James D. Ross						January	7 10, 199	2:0	O AM
Examiner	4a Facility Nama (If not institution, give	street and number)			4	b. City, Town,	or Location of Deat	h 4c. County	of Death	
	13125 Vandalia Dr	ive				Rockv		Mon	tgomery	
Funeral Director	3/9-30-2221	x 7. Age ((In yrs. last birth	Months	1 Year Days		Hrs. 8. Dete of Bi Min. (Month, Di Jan. 2	th year) 6, 1929	9. Birthplace (State of Country) Virginia	or Forei
	Usuel Residence of Decedent 10a. Stete 10b. County		IOc. City, Town	or Location					10d Inside C	line I imi
and sho	MD Montgo			ville					3. Time of 2:00 99ar 2:00	
ms 23a or 28a-f show Cmist be notified at	10e. Street and Number 13125 Vandalia Dr	ive		10f. Zij	2085	3		10g. Citizen of V		
Full by Full	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates: 1				ispanic Origin n, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Rec Blac Specify	k, White, atc.	
	15. Decedent's Edu (Specify only highest grad	le completed)		Decedent's Usu Give kind of wo ife. DO NOT u	vrk done d	during most of	working	16b. Kind of Bu	siness/Industry	
	Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Tec	hniciar	ı	10 Mathada	Name (First, Middle	Sear		
Be vog	Jean Ross						race Ward	, Melderi Sumam	a)	
marke marke To		and Delet	405-1	Anthon Address	. /011			Oh T	Onto Tie Codel	
T le r	19e. Informent's Neme/Retationship (T) Ann F. Ross	(wife)					e, Rockvi			
Heal arm 2 other	20a. Method of Disposition	("110)	20b. Place of E	Disposition /Ne	me of		Dete	-	Spomery 9. Birthplace (Stete or Country) Virginia 10d. Inside City 1 Yes 11 Yes 12 Yes 15 American Indian, White, etc. White iness/Industry 15 Approximate intervat Betw Onset and Dr. DAYS 10 Yes 11 Yes 12 Yes 14 Yes 15 Approximate Intervat Betw Onset and Dr. DAYS 16 (Specify) 1 Yes 16 (Specify) 17 Or Rural Route Numb	
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/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	PNEVI	MONA						DAYS	
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s certifica director,	25. Wes case referred to medical examiner?					26. Place of	Deeth (Check only	one)		
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	27. Manuer of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	(ear) 28b. Tir	ne of ury M	28c. Injun Worl	yat k? Yes 2∐No		how injury occurs	red	
within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (/ - At home, fem (Specify)	n, street, tector	y, office		28t, Location City or To	(Street and Numb wn, State)	er or Rural Route Nur	nber,
n 24 hour ne Funer pletely fill edical	29a. Certifier (Check only 2 Medical Exami	ner: On the basis of ea and manner state	camination and/	deeth occurred or investigation	at the tim , in my o	ne, date and p pinion, deeth o	lace, end due to the occurred et the time,	cause(s) end ma , dete and place,	nner es stated. and due to the ceuse(s)
C 2 0 0	29b. Signature and life of certifier / //	2/1 0	44.0	29		e number		29d. Date signed	(Month, Dey, Year)	
1	De Brosly)	1 (my	ME		03	31761		/////	/77	
Toth	30. Name and address of person who oc BUAN M, O'CONN		th (Item 23a) (T	ype, Print)			FREDER	OICK A	177	()



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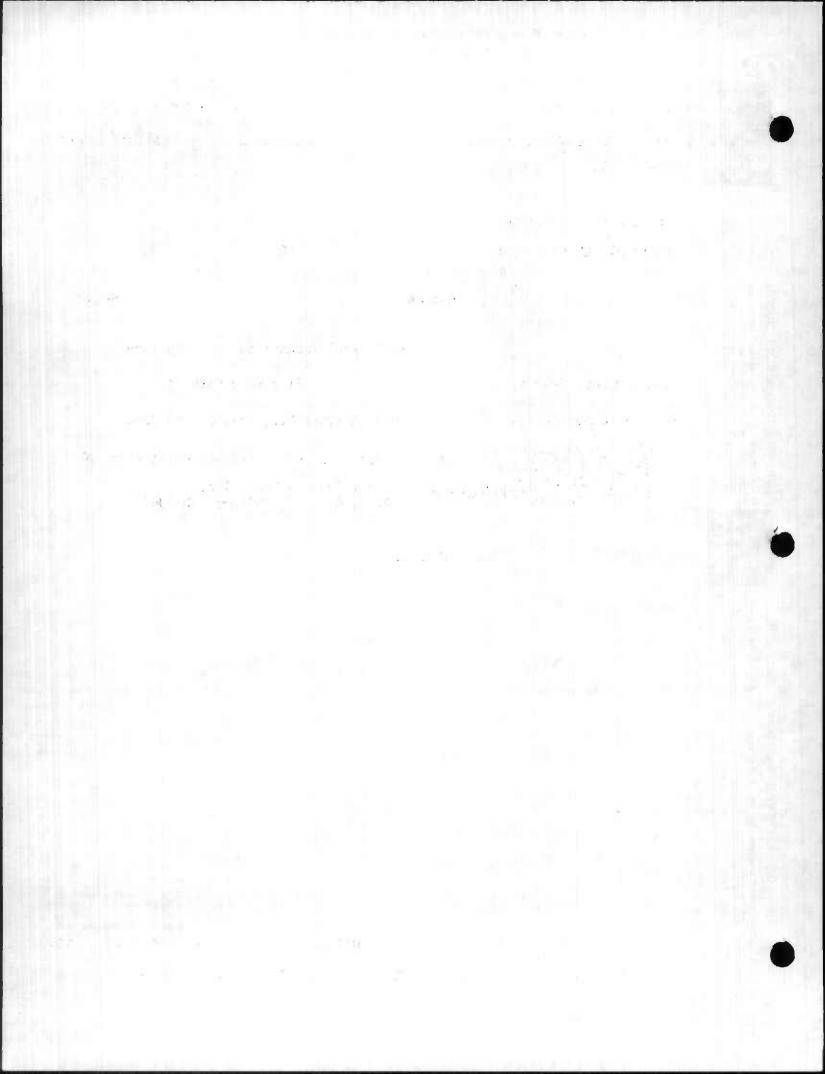
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kamine	er	4a. Facility Name (If not institu							4b. City, To	own, or Lo	cation of Death	h 4c. Count	y of Death	h	
-		HEBREW HOME					1 10 10	E- THOU		KVILI			TGOM	ERY	
eral ctor		5. Social Security Number 216-15-8927 Usual Residence of Decedent	6. Se	9X □M 2尺F	7. Age (In	yrs. last birtl	rs. Month	der 1 Year is Days		r 24 Hrs. Min.	8. Date of Bird (Month, Da MARCH 2	10 Year) 25,1911	9. Birth Con RUS	nplace (State ynth) SIA	or Forei
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1	ğ	MARYLAND MON	TGON	IERY	В	BETHESI	DA							1 ₹ Ye	s 2 🗆 N
	2	10e. Street and Number					10f.	Zip Code				10g. Citizen of	What Cou	untry?	
	0	5603 LONE OAK	DRI	VE			2	0814				UNITED	STA	ΓES	
	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ M 3 ☒ Widowed 4 □ Divorce		12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	rces? 2∭ No ⁄e	in U,S.	If Yes, s	cedent of I pecify Cub	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)		ick, White	rican Indian, o, etc.	
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90	Be Completed	(Specify only high	hest grad	de completed)	4		(Give kind of life. DO NO	work done use retire	during mos	st of worki	ng	100.14.10.01.0	Business/Industry		
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0	9	17. Father's Name (First, Midd	e, Last)						18. Moth	er's Name	ame (First, Middle, Malden Surname)				
	0	DAVID NEMENM	AN						(NOT	AVAI	LABLE)				
		19a. Informant's Name/Relation	nship (T	ype, Print)		19b.	Mailing Addre	ss (Stree	t end Numb	er or Rura	I Route Numbe	Number, City or Town, State, .			
		VLADISLAV RYA	BOY	(SC	ON)	560	3 LONE	OAK	DRIV	E - F	BETHESD	A, MARY	LAND	20814	
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Physician /Medical Examiner	23a. Part 1. Enter the dise shock, or heart tailur Immediate Cause (Final disease or condition	ase, or com e. List only	one cause on eac	used the death.	Do not ent	er the mode of	dying, such as	cerdiac or res	olretory arr	est,	Api	proximate erval Between eset and Death
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this aldi	1 Yes 2 No 27. Manner ot Death 1 Neturel 5 2 Accident	Pending investigation	28a. Date of (Month,		R/Outpatien 28b. Time of Injury	28c. [njury at Work? 1 🗆 Yes 2 🗆	28d. I		ence 8 □Oth ow injury occur		
tel or Attending P rs after death. al Director: After t led in by the funera Certification:		Could not b determined	286. Place o	t Injury - At hom g, etc. (Specify)	ne, farm, str	eet, tactory, off	ce	28t. L	ocation (S City or Tow	treet and Numb n, State)	per or Rural Ro	oute Number,
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To the comp	29b. Signature and title of	certifier	MOL	~		29c. Lic	ense number 352			9d. Date signe		
	30. Name and address of the KR1 SHAN IN	OHTAI	completed cause	ot death (Item 2	BOX	2729,	LA PI	LATA,	MD	20646		

Registrar

JAN 2 2 1999 32. Registrar's Signature & Aponta



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 1:48A.M LMINER /Medical 4b. City, Town, or Location 4e. Fecility Name (If not institution, give street and number) n of De **Examiner** WESTMINSTER If Under 24 Hrs. 8. Dala of Birth CARROLL KOAD Social Security Number If Under 1 Year Birth Dey, Year) 20 1909 7. Aga (In yrs. last birthday) Birthpieca (Stete or Foreign Country) **Funeral** 219.20.1258 10 M 20 F Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examine Investor notified at 10a Stete County 10c. City, Town or Location 10d. inside City Limits WESTMINE 1 Yas 2 No Director 10e. Street end Number 10g. Citizen of Whet Country? 211 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Rece - American Indien, Black, Whita, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forcas? 1 Yes 2 No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) TICKET AGENT Eether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middla, Maldan Be GAMBER . Informent's Name/Reletionship (Type, Print) WESTMINISTER, MAYLLAND 21158 WELT 20e. Method of Disposition 20b. Piece of Disposition (Name cometery, cremetory or other 20c. Location - Clty or Town, Stete 1/18/99 1 Buriel 2 □ Cremation 3 □ Removel from State BAUST Church CEMETERY 22. Name end Address of Fecility Pri H5 FW 412 WASHINGTON ROAD a death. Do not enter the mode of dying, such as ardiac or respiratory erre-4 ☐ Donetion 5 ☐ Other (Specify) ure of Funeral Service Licen HOME & ChAPEL Approximate Intervel Between Onsel and Death **Physician** IR VICAL /Medical immediate Cause (Final 1 marca diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner physician end the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting In deeth) Last Due to (or es e consequence of): Physician/Medical Dua to (or es e consequenca of): USB been signed by the atte should be detached for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings availabla prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 1 ☐ Yes ■ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Othar: 4 Nursing Homa Certification: To 1 Yes 22 No. 1 Inpaliant 2 ER/Outpetient 3 DOA Hasidence 6 Other (Specify) funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Plece of Injury - Al home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as steted. 2 Medical Exeminer: On the bests of exeminetion end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) end menner stated. Medical

State Registrar 31. Date filed (Month, Dey, Year)

29b. Signatur

32. Registrer's Signeture

completed cause of deeth (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician:

certificate

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Funeral Director: Al

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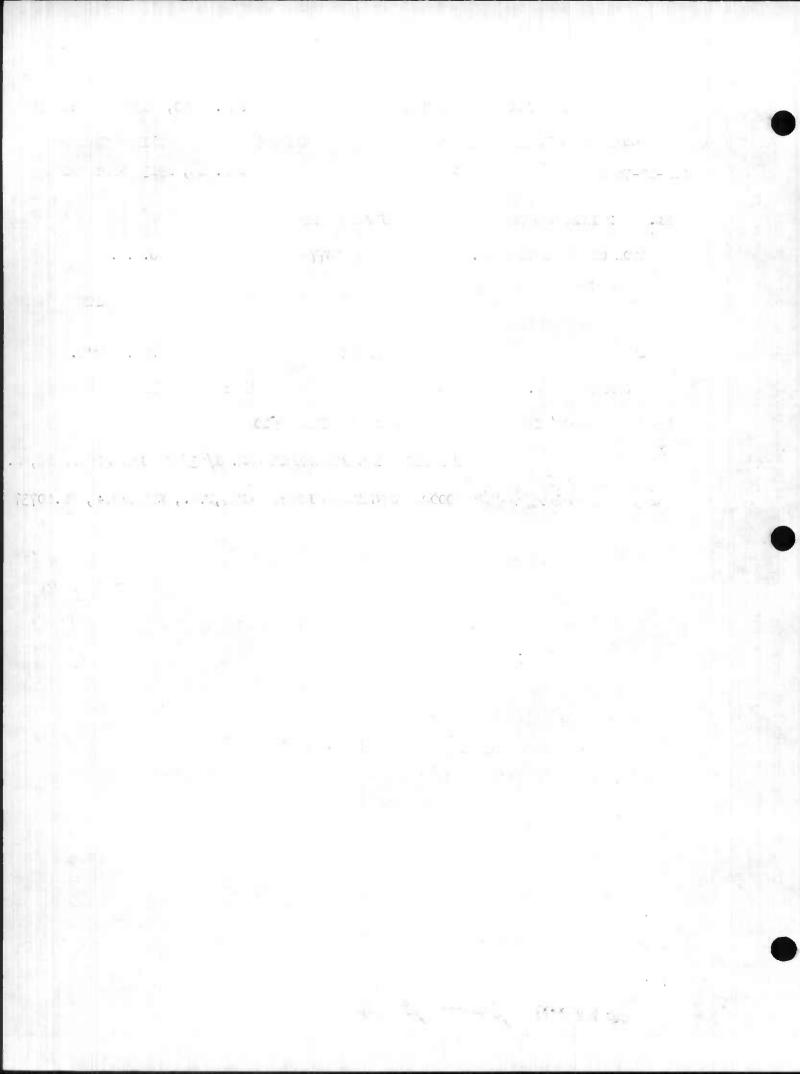
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	30. Name and address of person who con	mpleted cause of death (Ite	om 23a) (Type, F) <u> </u>		UANUARY	14,	בבבד	
	MELECIA SANTOS	M.D. VA MA	RYLAND	HEALTH (CARE SYST	EM, PERR	Y POINT	MD :	21902	
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State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 6 5 1

					Ce	rtificat	e of l	Death		Re	g. No.		2001
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Funeral	5. Social Security		Sex 1X0 M 2□ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)		place (State or Foreign
Director	218-12-7	666	INOM 2LIF	85	Yrs.		1			FEB. 15	, 1913	MAF	RYLAND
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rith the Ma or 28e-f e	10e. Street and Nu	1	FOUGES			10f. Zip		MIDON	0	10	ng. Citizen of V	What Cou	ntrv?
with your control		1 CROOM S	TATTON :	RD			207	779				5. A.	
72 hours effer death with the Maryland natural; or Hema 23a or 28a-f show after Examiner must be notified at	11. Marital Status	2 0110011 0	12. Was Dece	dent Ever in U.	S. 13.	Was Dece			igin? (Sp	ecify Yes or No- Rican, etc.)	14. Rac	e - Americ	can Indian,
) # # # E		ried 2 Married	Armed For	2 🔯 No						Hican, etc.)	2.711	k, White,	etc.
72 hours of natural, or	3 ☐ Widowed	4 ☐ Divorced	If Yes, Giv Year or Da	e ites:		1□ Yes	טאו נאָנַי	Specify			Specify	WH	ITE
72 h	(Spe Elementary/Sec 12	15. Decedent's E-	ducation ade completed)		(Give	dent's Usua kind of wo	rk done	during mos	st of work	ing	6b. Kind of Bu	siness/In	dustry
d within giene.	Elementary/Sec		College (1	-4or 5+)	`life.	DO NOT u	se retired	3)			- 1		
other u		(First, Middle, Last	1			CLEF	KK.	10 Moth	ada Alam	e (First, Middle, N). GC	OV'T.
	Ď			04000	175			IS. MOUT					
should nd Men marke umatic	-	AMES lame/Relationship (S. Time Print	SASSC	1	ina Addraes	/Street	and Numb		MARY al Route Number,	WILS		Codel
end 2 sho saith end n 27 is m	MARIE	SASSCER/						METE	#10	an ricord rearricos,	Ony or Tours	Outro, and	, , , , , , , , , , , , , , , , , , , ,
Health Health other tr	20a. Method of Dis		WILE	20b. P	lace of Disp	osition (Nar	ne of		#10	Date 2	Oc. Location -	City or To	own, State
Pages mt: If it		☐ Cremation 3 ☐ 5 ☐ Other (Specif		state	emetery, cre				OII D	EM 1/02	/00 III	משספ	MART RODO M
		uneral Service Lice		ITAL		2. Name ar				EM. 1/43	/99 01	FER	MARLBORO, M
Demit. Deperminimoral	11/1/	2/////	mller	All woo	007	TOTABATOR	DO T	כו הוואי זה	AT TT	OMETER TO A	DTIT	TA CICIO	E MD 0073
	23a. Part1. Enter	the disease, or com art tailure. List only	plications that ca	MOO	Do not er	ter the mod	e of dyin	o, such as	AL H	or respiratory arre	st, RIVE	KUAL	E, MD. 2073
) Physician	shock, or he	art tailure. List only	one cause on e	ach line.								i	Interval Between Onset and Death
/Medical	Immediate Cause disease or condition	(Final	00 14	. 0.10	to	011	£ 04	£	will.	50		į	Iweek
Examiner	resulting in death)		· Mult	Due to (o	as a conse	guence of):	lau	()	2110			1	Tweek
7 -			Covo	ective	hea	nt	fail	ove				1	5/1998
requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the buriel-transit	Sequentially list of	onditions,	Ь.	Due to (or	r as a conse	quence of):			0			1	1
C Legis		mmediate erlying	. Acu	te n	1400	zvelie	el.	in.	fau	ction		1	1/14/99
ifficate be on a straight of the burdel.	that initiated event resulting in death)	s Last	0	Due to (or	as a conse	quence of):							
nding p			. Kei	ral	iusu	traien	14	1					10/99
at the death ce d by the attendi etached for us													
by the	Part II. Other signi	ficant conditions o	contributing to de	ath but not resu	liting in the	underlying o	ause giv	en in Part	1.	23b. Did to	. 1	ntribute t	o the cause of death?
as that the igned by the be detached	Covor	ravy av	zhevy	dise	ese					1 T	1 2)S-No	3 Pro	bably 4 Unknown
Physician: The law requires the line certificate has been signed rail director, page 2 should be described.		1					30		100	24a, Was ar	autopsy	24b. W	ere autopsy tindings
been s should	5/p.	Hule	Myo ca	well.	int	aver	ou	11	45	perform	ned?	CC	vailable prior to empletion of cause death?
The law requir sate has been a pege 2 should	Δ11	POLLOS	Myo co	1 8	tatu	5_				40.8	s 25(No		☐ Yes 2☐ No
letan: The			10(000-0		-				n -1 Door	1 ☐ Ye	/	''	LITES ZLINO
Physician: this certific ral director.	1 Ves 20	(No	Hospital:	npatient 2	ER/Outpatie	ot 3 DC	Oth	or.		oma 5 Reside		ar /Snani	6v)
ang Phy After this funeral of		th		(Injury	28b. Time o		8c. Injur		disang i k	28d. Describe ho			777
Affending R r deeth. ector: Affer by the funer	1 Natural 2 Accident	5 Pending investigation		n, Day Year)	Injury	М		Yes 2	No				
or Attending after deeth. Director: After d in by the fune	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	286. Place	of Injury - At ho	me, farm, s	reet, factor	r, office			28f. Location (St. City or Town		er or Run	al Route Number,
Les or Attending P in a flar deeth. al Director: After it ed in by the funer.			Dunos	ly, etc. (Specify	,					ony or roun	, orang		
To the Hospital or At within 24 hours after or to the Funeral Direct completely filled in by		12 Certifying Ph	ysician: To the	best of my know	viedge, deal	th occurred	at the tin	ne, date ar	nd place,	and due to the ca	use(s) and ma	nner as s	stated.
To the P To the F complete			and mann										10.000
5 N CO	29b. Signature and	title of certifier	beeup	rela-	un	290	Licens	2 6 C	40	28	d. Date signer		
1	Meu											-	999
13	30. Name and add	ress of person who	completed cause	of death (Item	23a) (Type	Print)	()pno	2. V	larlho	VO N	10	20772
	31. Date filed (Mor	oth Day Years	32 0	rgistrar's Signal	ura d	1		rr	- 1	(~10100			
State Registrar			99	Para Signal	B.	do	ach						
	- Ali	~~~	//										



	State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 6 5 2 Certificate of Death											
Decedent's Nama (First, Middle, Last)			00	Timoato	OIL	Juan		2. Data of D			3. Tima o	Death
		nest	Schla-	retzki				Month	Day 19, 1	Year	8:10	
4a Facility Nama (If not institution, give			DCIII a	ICCARI	41	b. City, To	wn, or L	ocation of Dea	3	nty of Deal		131
Wilson Health Car						Gait				tgome		
Social Security Number 6. Sec.		Age (In yrs. li	ast birthday	If Under 1	1 Yaar	If Under	24 Hrs.			-	2	or Foreign
170 12 1203	M 2 F	78	Yrs.	Months	Days	Hours	Min.	Feb. 2	0, 1920	Il	thplace (State of puntry) linois	
Usual Rasidence of Decedent 10a. Stata 10b. County		10c City	, Town or L	ocation							10d. Inside C	ity Limite
												2□No
Maryland Montgom	ery	Ga	ither		0-4-				40-0%	1110 - 1 0	-	
				10f. Zip C	C008				10g. Citizen o	10g. Citizen of What Country?		
403 Russell Avenu		at Ever in 116	6 142		0877		nin2 /C-	naih. Van az N	United		erican Indian,	
	12. Was Deceder Armed Force	5?	5. 13.	If Yas, specif	ty Cubar	n, Maxicar	, Puarto	pecify Yas or No Rican, atc.)		lack, Whit		
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Types 2 If Yes, Give Year or Date:			1 Yes 2	No No	Specity:			Spec	ify: LJ	nite	
15. Decedent's Edu		WW I		edent's Usual	Occupa	ition			16b. Kind of			
(Specify only highest grade	completed)		(Give	e kind of work DO NOT use	done di	uring mos	t of work	king	TOU. KING OF	Duaniosa	inoustry	
Elementary/Secondary (0-12)	College (1-4o	r 5+)		fessor					Univer	sity	of Mar	vland
17. Fathar's Nama (First, Middle, Last)						18. Motha	r's Nam	a (First, Middle	e, Maiden Sum			
Walter Schlaretz	k i					Ann		'ara T	avlor			
19a. Informant's Name/Relationship (Ty			19h Meil	ing Addrass /	(Street a	Anna and Numbe		7	ber, City or Tow	m State	Zin Code)	
Eleanor C. Schlare		(wife)		e as 1			J. O. 112	21710010710111	boi, ony or row	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	L# 0000/	
20a. Mathod of Disposition	CORL	20b. Pl	ace of Disp	osition (Name	e of			Date	20c. Location	n - City or	Town. Stata	
1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from Stat	9		matory or oth			1	21 00				1
4 Donation 5 Other (Specify)	. 1	Cire	-	ke Cre				-21-99	Beltsv	rire,	maryı	and
21. Signature of Funeral Service License	1 0	4		2. Name and Rapp Fi				ces, P	. A.			
Coun X	1. 10	17	9 9	933 Gis	st A	venu	e, S	ilver :	Spring,	MD 2	20910	
23a. Part1. Entar tha disease, or compli shock, or heart feilure. List only or	cations that caus le cause on each	ed the death line.	. Do not en	itar tha moda	of dying	, such as	cardiac	or raspiratory	arrest,		Approximati Interval Bet	ween
The second secon											Onset and	Death
Immediata Causa (Final diseasa or condition	Conges	stive 1	Heart	Failu	re						30 hour	rs
rasulting in death)				quance of):								
	Arteri	loscle	rotic	Cardio	ovas	cular	r Di	sease				
Sequentially list conditions, if any, leading to immediata		Due to (or	as a conse	quence of):	1							
cause. Enter Underlying Cause (Disease or injury												
that initiated events rasulting in death) Last	•	Due to (or	as a conse	quence of):								
Part II. Other significant conditions con	tributing to death	but not resu	Iting in the u	underlying car	usa give	n in Part I		23b. Dic	d tobacco use	contribute	to the cause	of death?
Severe Anemia; Ch	ronic Ly	mphocy	vtic T	.aukam-	ia.			10	Yes 2⊠ No	3 P	robably 4	Unknowr
Dovoto Intende, on	ronic by	mprioc	y cic i	ocarcii.	Lag			-				
Parkinson's Disea	se: Deme	ntia:	Cerel	oral At	trop	hv			s an autopsy formed?		Were autopsy available prior	to
		-									completion of of death?	ause
								1□	Yas 2 No		1 Yas 2	No
25. Was case referred to medical axaminer?						26. Place	of Dee	th (Check only	one)			
1 Yes 2 No	ospitat:	tient 2 E	ER/Outpatie	nt 3 DOA	Othe	r: 4 🙀 Nu	rsing H	ome 5 Res	sidence 6 🗆 C	ther (Spe	icity)	
27. Manner of Death 1 ☑Neturel 5 ☐ Pending	28a. Date of In (Month, L	jury Day Year)	28b. Tima o	28	c. Injury Work	at ?		28d. Describe	how injury occ	urred		
2 Accident invastigation			,,,,,,	М		/as 2□	No					
3 Suicide 6 Could not be determined	28e. Place of I	njury - At hor etc. (Specify)	ma, farm, st	treet, factory,	office				(Street and Nur own, State)	mber or R	ural Route Nun	nber,
	Julian ig,	our (openiy)						y **	,,			
29a. Certifier 1 ☐ Certifying Physic (Check only one)	ician: To the bes	of examination	rledge, deat on and/or in	th occurred et	t tha time	a, dala an inion, daa	d place, th occur	and dua to the red at the time	a cause(s) and on, date and place	manner a: e, and du	s stated. a to tha cause(s	s)
29b. Signature and title of certilier			1	29c.	Licensa	number			29d. Data sign	ned (Mont	th, Day, Year)	
1 H. Robert	Lieu	4	- Che	ed I	0 04	115					, 1999	
30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type,	, Print)								
H. Robert Birschb	ach, M.	D., 6	6320 I	Democra	acy	Blvd.	, B	ethesda	a, MD 2	20817		

State

Registrar

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Medical Empires must be notified at once.

Physician /Medical **Examiner**

within 24 hours after death.

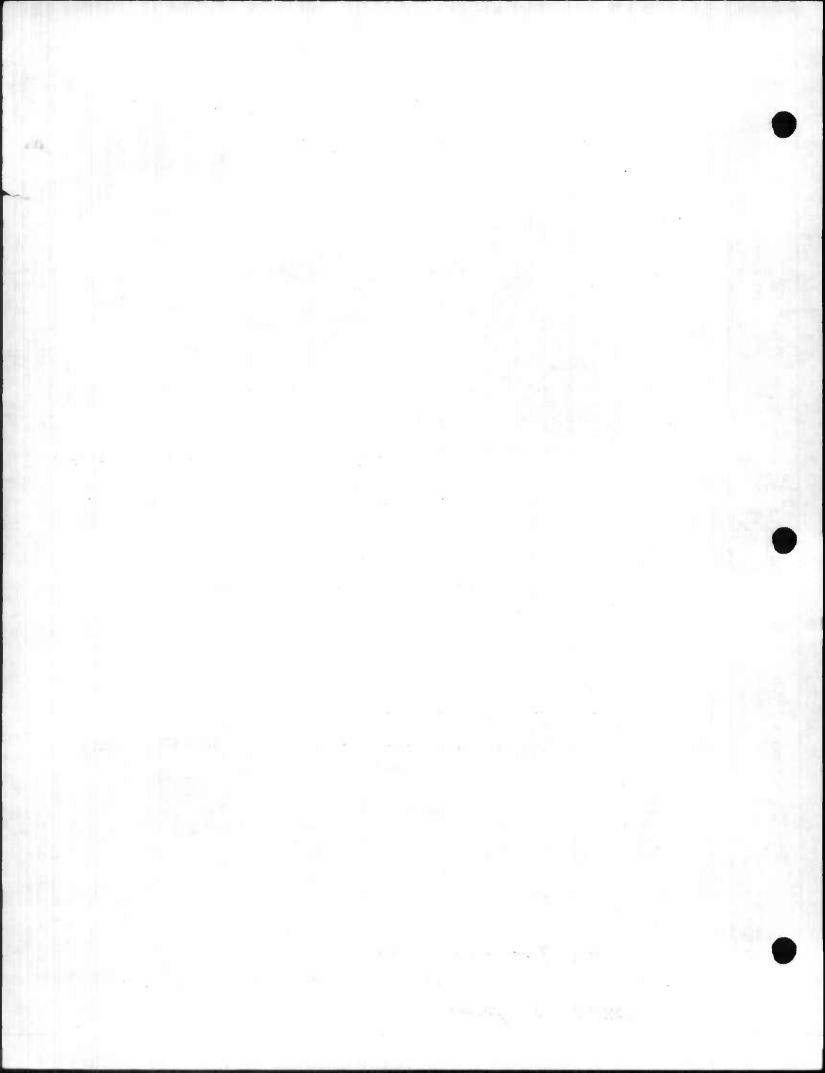
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baitimore, Maryland 21215-0020

31. Data filed (Month, Day, Year)

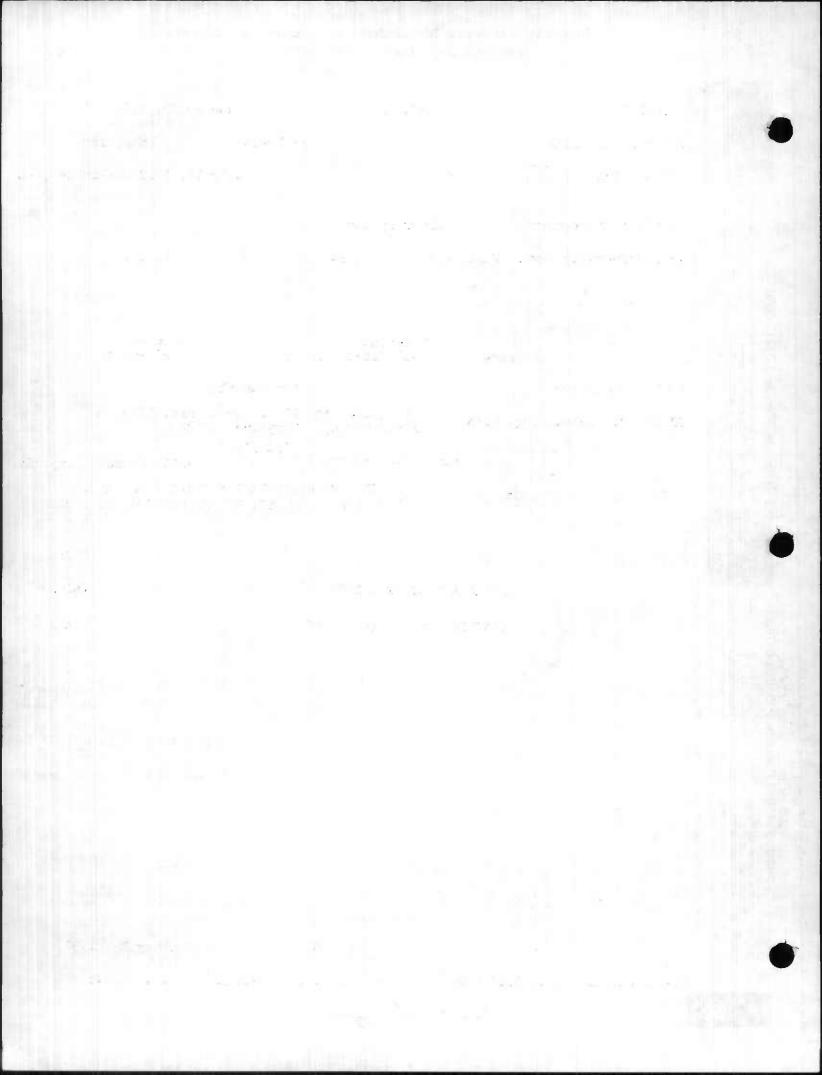
JAN 2 2 1999

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Q

							rtificate o	f Death		Reg. No.	U	2653
	Physicia	an	Decedent's Name (First, Middle, L.	ast)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		SHELDON		SCHLO	SSBER	.G	4. 65. 7-6-	January			1:58 AM
	· Examin	er	4a Facility Name (If not institution, g	ive street and number)				4b. City, Town, or		4c. County	of Death	
			Suburban Hospital				If Under 1 Yea	Betheso			gome	
	Funeral			Sex 7. Ag	e (In yrs. las	st birthdey) Yrs.	Months Day		(Month, De	y, Year)	9. Birthp	place (Stete or Foreign
L	Director		577-44-3143 Usuai Residence of Decedent		66				July 14	4, 1932	Wash	ington, DC
	Mand Mand		10a. Stata 10b. County		10c. City,	Town or Lo	ocation				1	IOd. Insida City Limits
	Man	to	Maryland Montgon	erv	S 1 1 ·	var S	pring					ty⊒Yes 2□ No
1	1 28a	Director	10e. Street and Number	icly		VEL D	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	death with the Maryland ms 23s or 28s-f show		1121 University H	lvd. West	. #11	15	20902	2		U.S.A		
	9 9 9	Funeral	11. Marital Status	12. Was Decedent Armed Forces?			Was Decedent o	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No	14. Race	e - Americ	ean Indian,
	or should be hied within 72 hours after death with the Matylan th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Madical Examinar must be nothled as	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 You If Yes, Giva Year or Dates:	No		1☐ Yes 2☐√N		, , , , , , , , , , , , , , , , , , , ,	Specify		ite
	2 no	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occ	supation na during most of wo	rkina	16b. Kind of Bu	siness/Inc	dustry
	an an	pje	(Specify only highest g Elemantary/Secondary (0-12)	College (1-4or 5	5+)	Merch	DO NOT use rela	ired)	rking	Hardwar	e	
	Hygiene. Thygiene. Ther than	5		4 Years			Estate 1	Broker		Real Es		
	tal Hygid d other event, to	Be	17. Father's Name (First, Middle, Las	(1)					ma (First, Middle,	Meiden Sumem	10)	
	should be nd Mental marked o imatic eve	To	Paul Schlossberg						Dworkin			
	and le mar		19a. Informant's Name/Relationship			19b. Maiii 1121	ng Address (Street	ity Blvd.	West.	Apt. 111	Stete, Zip) Code)
	f Haalth frem 27 other tr		Elaine B. Schloss	berg, Wife	OOL DIE	Silve	r Spring	g, Maryla	and 209	20c. Location -		
			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	cer	metary, cra	metory or other p	1/22 v	/1999	20c. Location -	City or 10	JWII, Stata
	tman tant:		4 ☐ Donation 5 ☐ Other (Spec	••	King			ial Garder	n -	Falls Ch	urch	, Virginia
V	Department of important: if any injury or page.		Signature of Fuperal Service Letter 23. Part Letter by din ase, or coshock, or north failure. List on	// //		CT	2. Name and Add EIN HEB 2 CARRO	DELL MEMOD	IAL FUNE	RAL HOME	E, IN	C.
			23 Part Enter the disease, or co shock, or mark failura. List on	mplications that ceused y ona causa on each li	the death.	Do not en	ter the mode of o	lying, such as cardia	c or respiratory a	rrest,	i	Approximata Interval Between Onset and Death
	hysician										- 1	Ondot and Doam
	/Medical Examiner		Immediate Cause (Final disease or condition rasulting in death)	a. HYPOX	IA							DAYS
		6	,		Due to (or a	as a conse	quence of):				1	
-	ner ner	nin		b. PULMO			TENSION				i	YEARS
	be asscur ician and burlai-tran	Examiner	Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Diseasa or Injury		Due to (or a	as a conse	quence of):					
	physician the burls		Cause (Diseasa or Injury that initiated events	V	Due to (or a		TAL DEF	ECT				YEARS
	phys is the	edicai	resulting in death) Last		Due to (or a	as a consec	quence or).					
	attending for use a	M	The Street	d								
	he alte	icla	Part II. Other eignificant conditions	contributing to death b	ut not result	ting In the u	inderlying ceuse	givan In Part I.	23b. Dld	tobacco use co	ntribute to	to the couse of death?
	by the	by Physician/M		31-1-1111			, ,		10	Yee 2√2 No	3 Pro	bably 4 Unknown
	a de de	by F									,	
	been signed by I should be detach	Completed							24a. Was perto	an autopsy rmed?	av co	/ere autopsy findings vailable prior to ompletion of ceuse i death?
	The law ate has page 2	ошо								Yes 2□No		☐ Yes 2☐xNo
	ficate or, pa	e Co	25. Was cese rafarred to medical					of Plans of D	ath (Check only			2 100 ELECTION
	a certific director,	00	examiner?	Hospital:	ant alle	B/Outcatio	nt 3 DOA	Othor	Home 5 Resi		er (Specie	(h)
	r bis	n: To	27. Manner of Death	28a. Date of Inju	ry 2	28b. Tima o		njury at Vork?		how injury occur		77
	or Attending after death. Director: Afte in by the fund	stion	1 Natural 5 Panding 2 Accident invastigat	(Month, De	y Year)	Injury		Vork? ☐ Yes 2☐ No				
	of the	fica	3 ☐ Suicide 6 ☐ Could not	A 286. Place of Inj	ury - At hom	ne, farm, st	reet, factory, office	ce	28f. Location (Street and Numb	er or Run	rel Route Number,
	d in Direction	Certification:	4 Homicide	building, et	c. (Specify)				City or To	wii, Sidid)		
A second	to the yeapprai of Attending Physicians. The lay within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (Physician: To the best aminer: On the basis of and manner st	examination							
1	To the comp	X	29b. Signature and title of certifier				29c. Lice	ense number		29d. Date signe	d (Month,	Dey, Year)
- 15	- 0		DA DA	kou"			MD4	0576		January	20,	1999
	W		30. Name and address of person wh									
			Ramin Oskoui, M.	D., 3301 Ne	ew Mex	cico A	Avenue,	N.W., Was	hington,	D.C.	2001	16
	Sta	-	31. Date filed (Month, Dey, Year)		ar's Signatu	ure 6	1	1.				
	Registr	ar	JAN 221	999	S. A. S.	p.	Soon.	a				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Dete of Deeth

3. Time of Death

01.12.1999 Yaar **Physician** 5:29 AM IRVING PAUL SCHWARTZ /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner ROCKVILLE MONTGOMERY HEBREW HOME OF GREATER WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** M 2□ F 82 Yrs. **Director** 155.03.7134 11.16.1916 NEW YORK Usuel Residenca of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show MONTGOMERY MARYLAND ¥ Yas 2 No Director ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò the Medical Examiner must be USA 20852 6121 MONTROSE ROAD or items 23a Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Raca - American Indien, 11. Marital Stetus Bieck, White, etc. efter 17 Yes 2 No WW II 1 Naver Merriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No WHITE À Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedant's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry COMBUSTION el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) ENGINEERING ENGINEER permit. Peges 1 end 2 should be flik Department of Health and Mentel Hy Important: If item 27 is marked othe eny Injury or other treumetre 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumame) ROSE SKLAR BARNEY SCHWARTZ 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 22033 19a. Informent's Neme/Reletionship (Type, Print) JANE THORSON/DAUGHTER 12562 SUMMIT MANOR DRIVE #403, FAIRFAX, VIRGINIA 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Ramoval from Stata MOUNT COMFORT CREMATORY 1.15.99 ALEXANDRIA, VIRGINIA 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility
EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 lications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory srrast, no cause on each line. 23s. Part1. Enter the diseesa, or compleshock, or haert failura. List only of Approximata Intarval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting In death) · CHRONIC RENAL FAILURE Examiner Due to (or as a consequence of) Due to (or es e consequence of): Examiner RENAL sicien end burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last certificate be execu ARTERIUSCLEROSIS ed by the attending physicien detached for use as the buria Box 68760 Physician/Medical Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the csuse of deeth? 1 Yee 2 No 3 Probably 4 Unknown SCHEMIC CARDIO MYOPATHY been signed by Records, 90 Completed 24e. Wes en eutopsy 24b. Wera eutopsy findings avsileble prior to PERIPHERAL VASCULAR DISEASE performed completion of cause of deeth? has page 1 Yas 2 No 1 □ Yas 2 □ No Division of Vital Be director. 25. Wes case referred to medical 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4™ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 2 1 Yas 2 No 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred spital or Attending P nours efter death. neral Director: After the Certification: 5 Pending investigation 1 Naturel Injury 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datermined 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, ferm, straet, fectory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours e Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and piece, and due to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) Medical completely end mannar stated.

State Registrar 31. Date filad (Month, Dev. Year) JAN 1 9 1999

29b. Signetura end titla of cartifiar

STEVEN

1. Decedent's Neme (First, Middle, Last)

IPSO MONTROXE ROAD, 6121 37. Registrer's Signeture

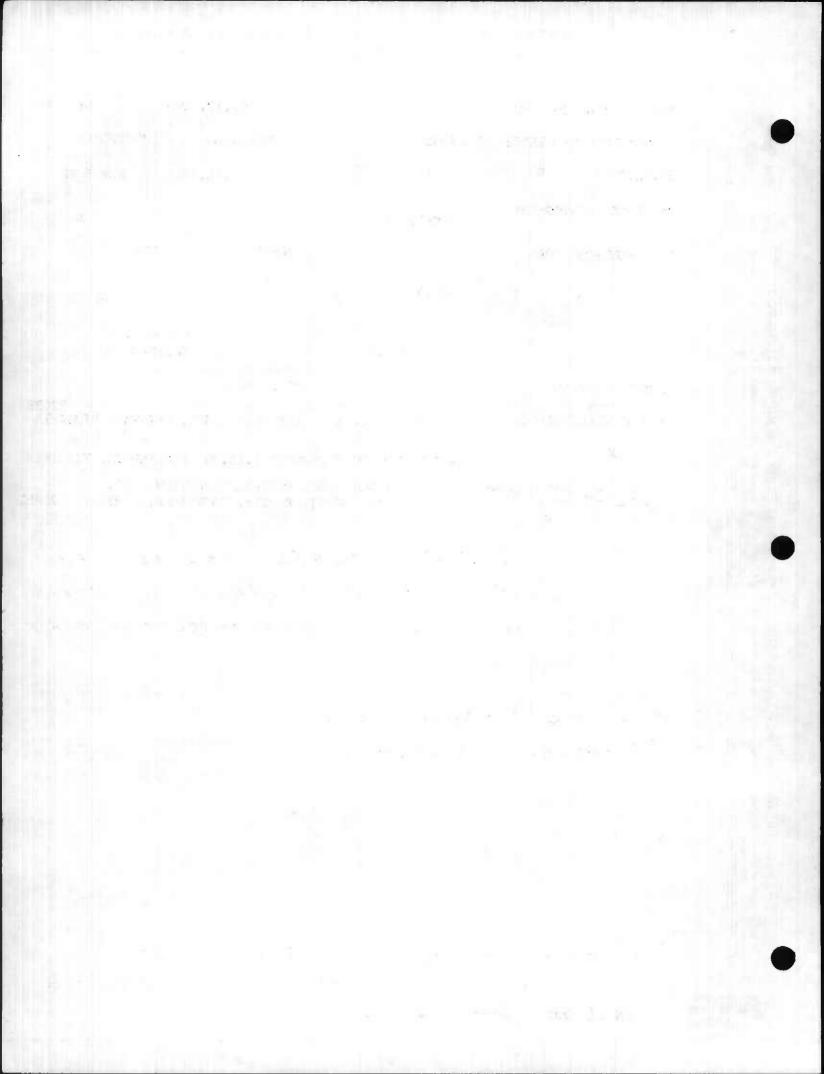
epan

30. Name end eddress of person who complated causa of death (Item 23a) (Type, Print)

29c. Licanse number

29d. Date signed (Month, Day, Year)

ROCKVILLE



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q ITEMS: #5 PER F.H. G770 4-23-99 WR. Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 7:00 PM SHIRLEY LEE SHERR /Medical JAN 1999 17 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Daeth **Examiner** HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 24 Hrs. Hours Min. 5. Social Security Number 577-09-7898 If Under 1 Year 7. Aga (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Birthplece (State or Foreign Country) 1□ M XXF Deys 88 Yrs. Director 597 09 7898 JULY 25, 1910 WASHINGTON DC Usual Residence of Deceden 10e. Stete 10b. County 10c. City, Town or Location or 28a-1 show 10d. Inside City Limits must be notified at Director Yes 2□ No WASHINGTON, D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 238 2800 QUEBEC #725, N.W. 20008 daath Funeral USA Herna 12. Wes Decedent Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. of haufu and Mental Hygiena.

'Itam Z7 is marked other than "natural" or leaother traumation. 1 ☐ Yes 2 😿 No if Yes, Giva 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced WHITE Yaar or Dates: Be Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ACCOUNTANT FEDERAL_GOVERNMENT 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) ROBERT 2 SHERR FLORENCE EDELSTEIN 19a. Informent's Name/Reletionship (Type, Print) permit. Pagas 1 and 2 sh Department of Haelth and Important: If Itam 27 is m any injury or other traum once. 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) MURRAY ZITVER ATTORNEY 5000 SUNNYSIDE AVE #101, BELTSVILLE, MD 20705 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20a, Method of Disposition 20c. Location - City or Town, Steta 1 ABurial 2 ☐ Cremation 1-21-1999 B DOther (St KING DAVID MEMORIAL GARDENS FALLS CHURCH, VA rvice 22. Name end Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 . Enter deeth. Do not anter the mode of dying, such as cardiac or respiretory errest, Approximata Intervel Batween Onset end Death **Physician** immediate Ceuse (Final disaese or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Examiner The law requires that the death cartificate be executed for usa as the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): Box 68760. Physician/Medical that initieted events resulting in deeth) Lest Due to (or es a consequença of): P.O. datached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 24b. Were autopsy findings eveileble prior to completion of causa of deeth? Completed 24a. Wes en eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital

director, page 2 should cartificata To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this cartification that the funeral director is the funeral director. Be

2

Certification:

Medical

27. Menner of Deeth 1 Naturel

2 Accident

3 ☐ Suicide

29a. Certifian (Check only

4 Homicide

25. Wes case referred to medical 1 Yes 2 No

> 5 Pending Investigation 6 Could not be determined

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et tha time, dete end place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted. 29b. Signeture end title of certifier

29c. Licansa number

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

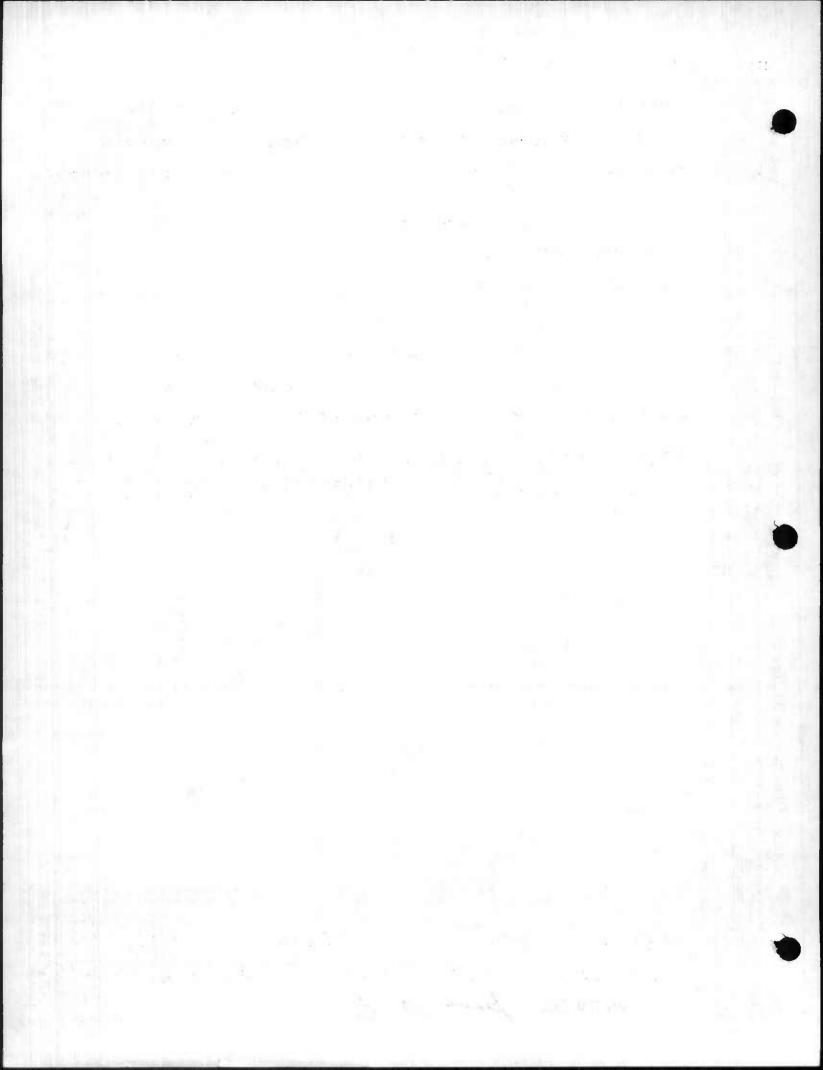
Buxt I. Fetelman MD, 6105 Months Se Fd, Rocky 16 MD

State Registrar

31. Dete filed (Month, Dey, Year)

JAN 20

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Doys Shorb Andrew Jan. 18, 1999 9:15P. /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner Prince George's Mariner Health Care Laurel 8. Dete of Birth (Month, Day, Yeer) Feb.19,1905 If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys XXM 2□ F Months Hours 215-44-8369 93 Yrs. Idaho Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified as Prince George's Maryland Beltsville 1 ☐ Yes XX No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20705 11111 Montgomery Road United States permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiena.

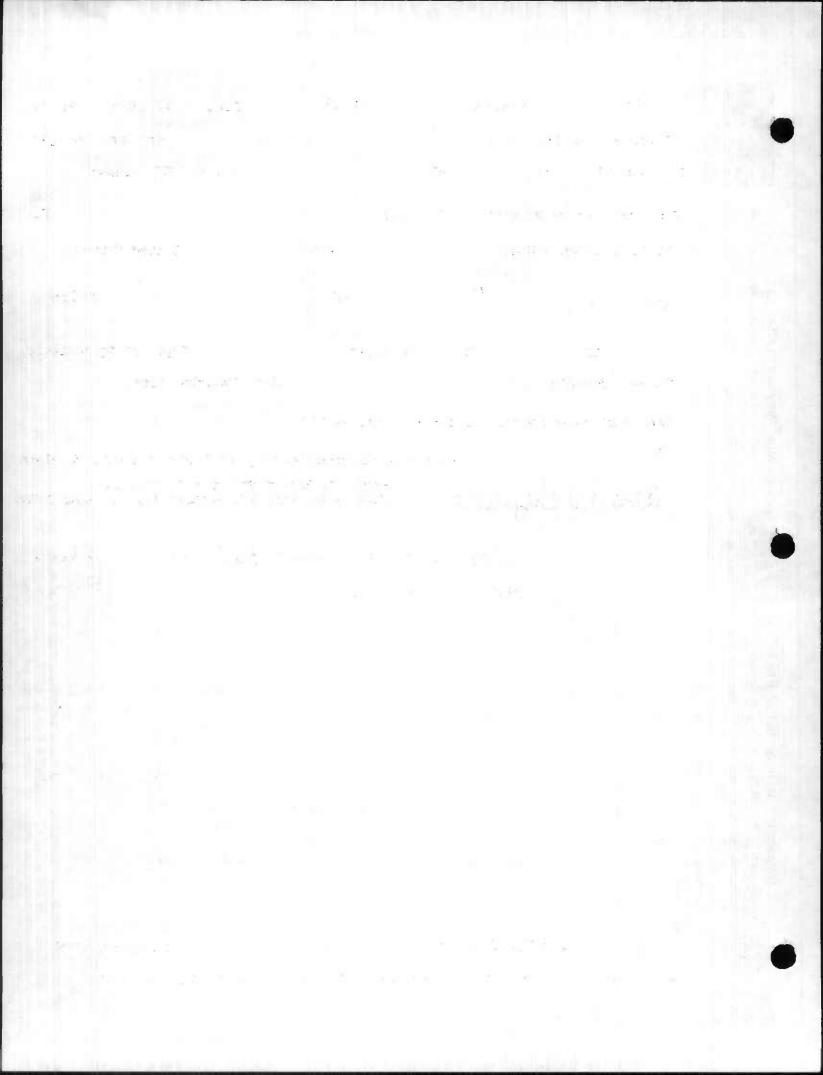
Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examples 200. Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🏋 No Specify: White p XX Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) 5+ Scientist Dept. of Agriculture 18. Mother's Neme (First, Middle, Meidan Sumama) 17. Father's Nama (First, Middla, Last) Be Cormac Joseph Talitha Moore Shorb Lilian 19e. Informant'a Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Carole Elizabeth Shorb (daughter) same as #10 20b. Placa of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition Warial 2 ☐ Cremation 3 ☐ Removel from State George Washington Cemetery 1/22/1999 Adelphi, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Pert1. Enter the disease, or complication, that caused the deeth. Do not enter the mode of dying, auch es cardiac or respiretory errest, shock, or heart feilure. List only one clime on aech lina. Approximete Interval Batween Onset end Deeth **Physician** /Medical Immediate Cause (Final heart failure disease or condition resulting in deeth) Examiner Examiner TIC STEMOSIS hysician and the burial-transit Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Records, P.O. Box 68760 physician certificate be Physician/Medical Due to (or as e consequence of): 88 980 0 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco was contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PV 24b. Were autopsy findings eveilable prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? page 2 has 1 ☐ Yas 2 (XNo 1 Yas 2XXX0 certificate Division of Vital or Attanding Physician: funeral director 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only ona) Othar: XXX Nursing Home 5 - Residence 6 - Other (Specify) 10 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: Al investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide Hospital 29a. Cartifiar XX Cartifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to tha causa(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated. To the within 2 29b. Signeture end title of certifiar 29c. License number 29d. Deta signad (Month, Day, Year) January 19, 1999 30. Name end eddress of person who complated causa of daeth (Itam 23a) (Type, Print) Paul Armstrong, M.D. 14201 Laurel Park Drive, #102 Laurel, Maryland 20707 31. Data filed (Month, Dey, Year) 32. Registrer's Signature

State Registrar

JAN 20 1999

B. Sports

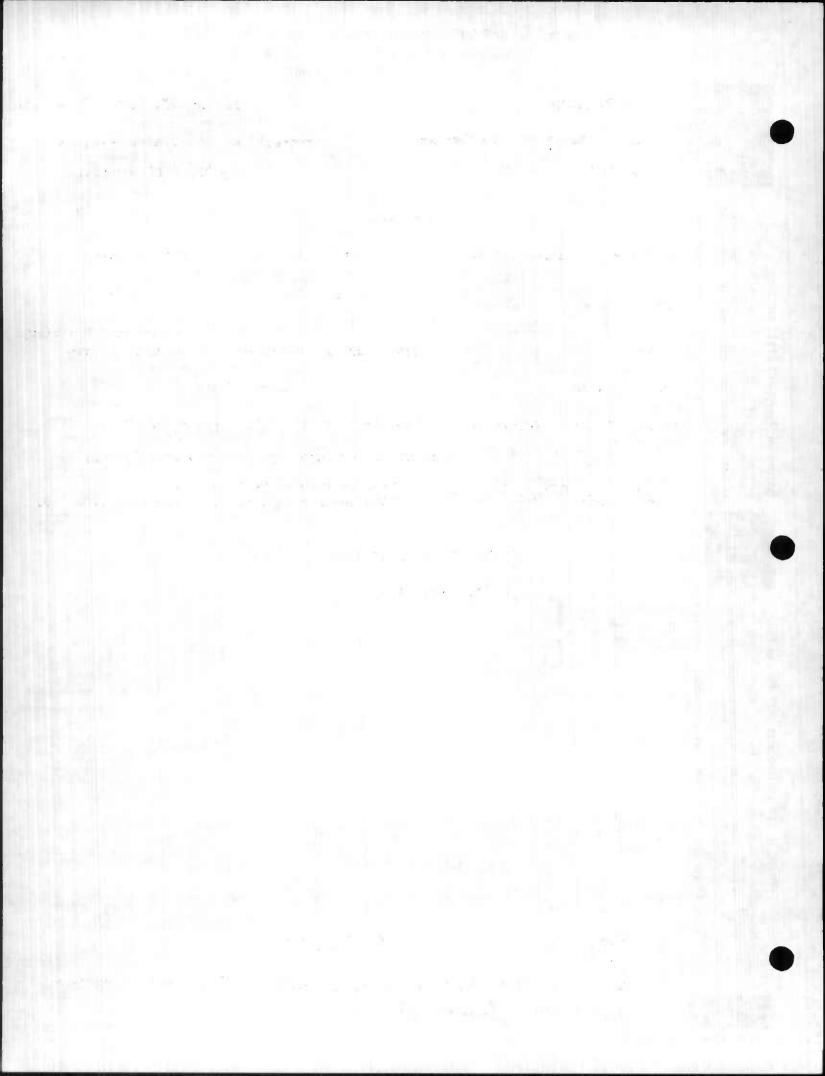


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 15, 1999 **Physician** CARRIE E. SMITH 2:00 a.m. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner St. Thomas Moore Nursing Center Hyattsville May If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 25, 19 Hyattsville Prince George's 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 F 81 212-14-5324 Yrs. Maryland **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23s or 26s-f show Example: must be notified at 1X Yes 2 No Washington, D.C. Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1377 Sheridan Street, N.W. 20011 United States Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Haalth and Mental Hygiane. Important: If Itam 27 is marked other than "natural", or iten any injury or other traumetic event, the Wedical Example DDE. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 Tes 2 No Specify: à 30 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Government Printing Elementary/Secondary (0-12) College (1-4or 5+) Proof reading supervisor Office 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Samuel Eades Saddie Ennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 216 Nicholson St. N.E., Washington, D.C. Carolyn Lynch 20011 (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State Gate of Heaven Cemetery 1/22/99 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenson 7400 Georgia Ave. N.W., Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ARBIO PULMORARY **Examiner** Examin physician end the bunal-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of) Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of) ettanding p SB signed by the e P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, py 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed peen paga 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No cartificata Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) funarai 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: After or Attending 1 Natural 5 Pending 1 Yes 2 No investigation after death. 2 Accident Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours at To the Funeral Di complataly filled is 29e. Certifier 1 🖄 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier MA 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DNYEJIAKA HAMEOVER PARKUAY GREETEBEET MARTLAND 20105 7325A VICTOR 31. Date tiled (Month, Day, Year) 32. Degistrar's Signature State

Registrar

JAN 2 1 1999

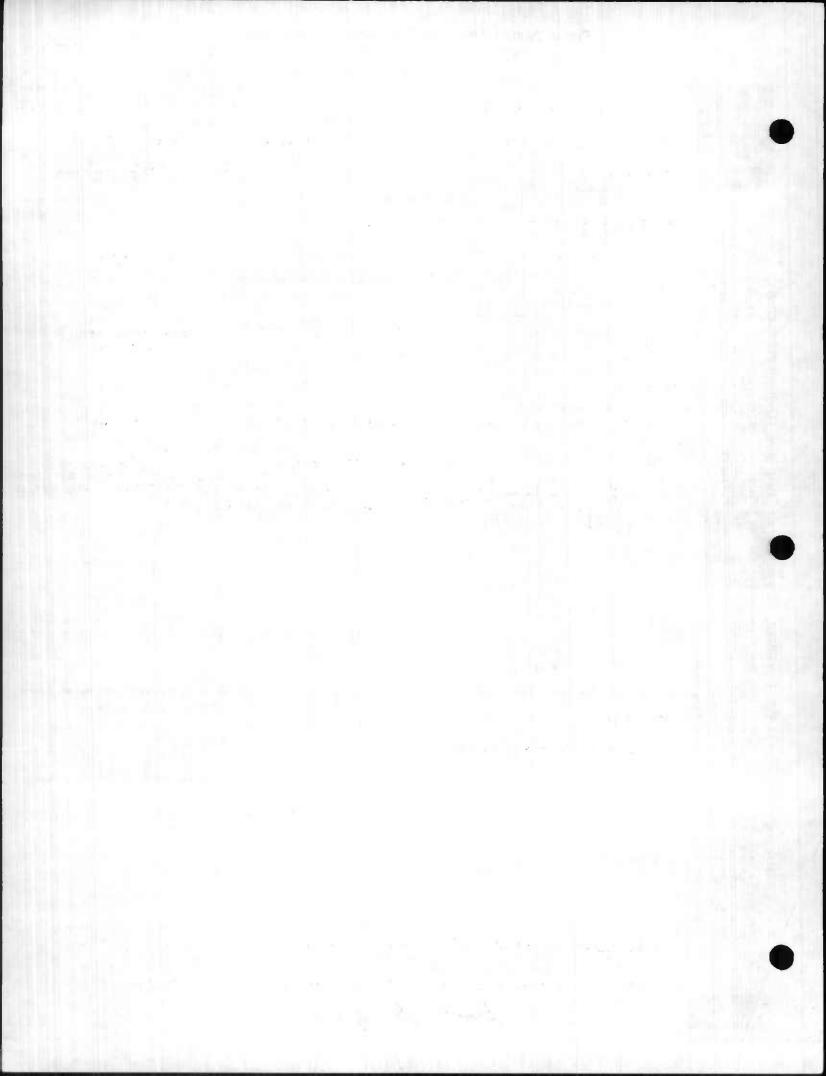


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 6 5 8

		100		061	uncat	e oi	Death		H	eg. No.		
1. Decedent's Neme (First, Min	ddie, Last)							2. Dete of Dee	Dey	Year	3. Time of Death
Marg	garet	Smith	1							19, 19	99	12:15 P.M.
	La Parille		ber)						cation of Death	,		
	-				T 1166 .							
							Hours	Min.	8. Date of Birth (Month, Dey	Year)	9. Birthpl	lece (State or Foreign try)
			96	118.				1	Nov. 18	, 1902	Penns	ylvania
	ntv		10c. Ci	tv. Town or Lo	ocation						10	Od. Inside City Limits
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	larried	Armed Fore	ces?	,,,,	If Yes, spe	cify Cub	an, Mexicar	n, Puerto F	Ricen, etc.)			
		If Yes, Give			1 Yes	2 XNo	Specify:			Specif	y: Whit	-0
				16e. Dece	dent's Usu	ei Occur	petion			16b. Kind of B		
(Specify only hig	hest gred	le completed)		(Give	kind of wo	ork done ise retire	duning mos	t of workin	ng			
Elementery/Secondary (0-12	2)	College (1-	4or 5+)							Agric	cultur	re
17. Father's Neme (First, Midd	lle, Last)	- 4		Nese	altin	. S C	18. Mothe	er's Neme	(First, Middle,	Meiden Sumer	ne)	
George Smith							Alic	ce i	Not Ava	ilable		
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23a. Parft. Eater the globase shock, of heart dilute. L	or compl ist only o	lications that ca ne ceuse on ee	used the dee ch line.	th. Do not en	ter the mo	de of dyir	ng, such es	cerdiac o	r respiretory err	est,		Approximete Intervel Between
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resulting in deeth)		0 .	Due to (or es e conse	quence of)	:			W		1	
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that initiated events		C	Due to (d	or es e consec	quenca of):							
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Pert II. Other algolificant cond	itiona co	ntributing to dea	ath but not res	sulting in the u	ınderlying	ceuse gi	ven in Pert	l.	23b. Did to	obacco usa co	ontributa to	the cause of death?
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Dearness						-						
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Peripheral	ascu	Tal Dis	ease									mpletion of ceuse deeth?
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25 Was case referred to med	ical		- ,				26 Place	e of Death				
exeminer?		Hospitel:	nationt 2F	EP/Outpetle	nt 2 🗆 D	OA Oth	hor				her (Specifi	w)
27. Manner of Death				-				-				y)
		(Month	, Day Year)	Injury	м							
Z L Mocidonii	ld not be	28e. Piece	of Injury - At h	ome, farm, st	reet, factor				28f. Location (5	treet end Num	ber or Rura	I Route Number,
3 ☐ Sulcide 6 ☐ Cou	ermined	buildin	g, etc. (Speci	Ty)	1001, 100101	,,			City or Tow			
3 ☐ Sulcide 6 ☐ Cou 4 ☐ Homicide dete				wledge deet	h occurred	l at the ti	me dete er	nd place e	and due to the o	euse(s) and m	anner as et	late d
4 Homicide dete	hina Dhu	elolen. To the b	and of my key			of the fir			Still due to the c			
4 Homicide dete			sls of examine			n, in my o	opinion, dee	th occurre	ed et the lime, o			
4 Homicide dete	al Exami		sls of examine		vestigetion		opinion, des se number	oth occurre			and due to	the cause(s)
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Maritel Stetus 12*Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edic (Specify only highest greet Elementery/Secondary (0-12) 17. Father's Neme (First, Middle, Last) George Smith 19e. Informant's Name/Relationship (Times) Marjorie A. Soude 20e. Method of Disposition 1 Burial 2 Cremetion 3 Burial 2 Bu	4a Facility Neme (If not institution, give street end numerically Neme (If not institution, give street end numerically Nemerically Number 5. Social Security Number 6. Sex 217-44-0401	Margaret Smith 4a Facility Neme (If not institution, give street and number) Carriage Hill-Bethesda 5. Social Security Number 217-44-0401 Usual Residence of Decedent 10a. State 10b. County 10c. Site 10b. County 10c. Street and Number 4018 Rickover Road 11. Maritel Status 12. 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Souder/Trustee 200. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) 1 Singular Service Lamber Stete 4 Donation 5 Other (Specify) Stroke 22. Name a Bethese or confident of the deeth. Do not enter the most of the string in deeth) Sequentially list conditions, if erry, leading to immediate Cause (Final disease or condition resulting in deeth) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying Deafness Peripheral Vascular Disease 25. Wes case referred to medical everwiner? 1 Ves 28 No 27. Manner of Doath 1 Marited Steven Scales of Injury that initiated events resulting in deeth) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying Deafness Peripheral Vascular Disease 25. Wes case referred to medical events resulting in deeth) 27. Manner of Doath 1 Marited Steven Scales of Injury that initiated events resulting in deeth) 28. Date of Injury 1 Jury 1	Margaret Smith 4a Facility Neme (If not institution, give street and number) Carriage Hill—Bethesda 5. Sociel Security Number 217-44-0401 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery 10c. Street and Number 4018 Rickover Road 11. Mariel Stetus 12. Wes Decedent Ever in U.S. 13. Was Decedent of If Yes, Spring 15. Never Married 16. Specify only highest grede completed) 17. Father's Name (First, Middle, Last) George Smith 19e. Informant's Name/Relationship (Type, Print) 17. Father's Name (First, Middle, Last) George Smith 19e. Informant's Name/Relationship (Type, Print) 18 Burial ≥ Correction 18 Burial ≥ Correction 19 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 10 Surial ≥ Correction 11 Surial ≥ Correction 12 Surial ≥ Correction 12 Surial ≥ Correction 13 Surial ≥ Correction 14 Surial ≥ Correction 15 Surial ≥ Correction 16 Surial ≥ Correction 17 Surial ≥ Correction 18 Surial ≥ Correction 19 Surial ≥ Correction 19 Surial ≥ Correction 19 Surial ≥ Correction 19 Surial ≥ Correction 19 Surial ≥ Correction 19 Suria	Margaret Smith 4s Facility Neme (if not institution, give street and number) Carriage Hill—Bethesda 5. Social Security Number 6. Sex 10	Margaret Smith 4a Facility Name (If not institution, give street and number) Carriage Hill—Bethesda 5. Social Security Number 217-44-0401 10a. Sizet 96	Margaret Smith Margaret Smith January Maruary M	Margaret Smith 46. Finding Name (if not institution, give street and number) Carriage Hill—Bethesda 5. Social Security Number 21.7 - 4.4 - 0.40.1 10. Size Pool	Margaret Smith Samith

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Registrar



State of Maryland / Department of Health and Mental Hygiene Q

		1 Decedentle Name (F7-14 AT	dla 1 = -43			Ce	rtificat	e of	Death	Tr		leg. No.	7/ 600	2659
/sicia	n	 Decedent's Name (First, Midd 	_		Manda	C				2	. Date of Dea Month	Day	Year	3. Time of Dear
ledica	ai -	la. Facility Name (If not institution			Marie	Spragu	ie		4h. City. Toy		tion of Death	20, 19		12:26 P
amine		Shady Grove	Adv	entis	st Hos				Rock	vill	.e	Mon	tgome	ry
eral tor		5. Social Security Number 266-19-6503	6. Sex 1 □	M 2 F	7. Age (In yrs. 4:		Months Months	Days	If Under 2 Hours	Min	Dete of Birth (Month, Dey pril 9	Year)	9. Birthpla Country Mich:	
1	- 1	Usual Residence of Decedent 10a. Stete 10b. Count	v		10c. Ci	ty, Town or L	ocation						100	d. Inside City Lir
	0	Maryland Mont	c omo:	W. T. T.		ckvill								1 X Yes 2 □
	Director	Maryland Mont 10e. Street and Number	gome	Ly	KO	CKVIII	10f. Zip	Code			1	0g. Citizen of V	What Countr	y?
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	Funeral	11. Marital Status			edent Ever in U	l,S. 13.	Was Deced	dent of H	lispanic Orig	in? (Specif	y Yes or No- can, etc.)		e - Americai	
1	2	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☒ Divorce		1 Tes If Yes, Giv Yeer or De	2 X No		1□ Yes			, 40,10 1110	Juli, 010.)	Specify		
	Completed	15. Decede (Specify only highe				16a. Dece	dent's Usua	ol Occup	ation	of working		16b. Kind of Bu		
	d.	Elementery/Secondary (0-12)		College (1	-4or 5+)				during most	or working				
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d	O I	17. Fether's Name (First, Middle							10/2/2007	-		Meiden Sumen	ne)	
1	0	David Graham		rague					Mary		Dunl	-		
		19a. Informent's Name/Retation							end Number	r or Rurel F	Route Number	r, City or Town,	Stete, Zip C	Code)
	-	Charles N. Pat	ters	on (i	iance)		me as			-	Date	20c. Location -	City of Tow	n State
		1 ☐ Burial 2 ☑ Cremation		moval from		Place of Disponentery, cre								iaryland
	-	4 ☐ Donation 5 ☐ Other (3		0	Cn	esapea			ss of Fecility		22-99	DETUSVI.	IIe, r	larylanc
-BOUG		21. Signature province	/ / logisee	D		-	Rapp	Fune	ral Se	ervic	es, P.	A.		
	-	On Ports Fotos the discourse	V .	Top	Y	D	933 G	ist	Avenue	e, Si	lver S	pring,		
-		23a. Part1. Enter the disease, of shock, or heart failure. Lis	t only one	e cause on e	ech line.	n. Do not en	ter the mod	e ot ayın	ng, such es d	ardiec or r	espiretory arr	est,	1 1	Approximate nterval Between Onset end Death
n el		tmmediate Cause (Final		1	7:	}		0	1.	101				
er		disease or condition resulting in death)	Θ.		rirr		5 (01	110	rep				jean
4	ĕ				Due to (or as a conse	quence or):							
1	Examiner	Sequentially list conditions	b.		Due to (c	or es e conse	quence of):							
		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury											i	
2	lcal	that initiated events resulting in death) Last	C.		Due to (d	r as e consec	quence of):							
16	To	,,	L.										1	
00	2		a.											
Dhyeloley	385	Part II. Other significant conditi	tons contr	ributing to de	ath but not res	ulting In the u	inderlying c	euse giv	ren in Part I.		23b. Dld to	bacco use co	ntribute to t	he cause of de
											1 🗆 Y	es 2 No	3 Probe	ibly 4 Unki
	0 0										24a. Was a	n autoney	24b Wer	e autopsy findin
0+0	212										perfor	med?	aveil	eble prior to pletion of ceuse
200	Completed										40.4	N.	of de	11
		25. Was cese referred to medical	21								1 U Y		10	Yes 2LXNo
ļ α	0	examiner?		spitat:	npatient 2	ED/Outpotion	nt 3 X DC	Oth	er.		Check only or		(0	
- ⊢	- -	27. Manger of Death			of Injury h, Dey Year)	ER/Outpaties 28b. Time of		8c. Injun Worl		-		ence 8 Oth ow injury occur		
i	2	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng igation	(Mont	h, Dey Year)	Injury	M		k? Yes 2□N	lo				
100		3 ☐ Suicide 6 ☐ Could	not be	28e. Place buildir	of Injury - At h	ome, farm, st	reet, factory	, office		28f	Location (Si City or Town	treet and Numb n, Stete)	per or Rural i	Route Number,
artification.		4 Homicide												
Cortification		29e. Certifier 1 Certifyl (Check only 2 Medical	ng Physic	er: On the ba	sls of examine	wledge, deat	h occurred a	at the tim	ne, date end pinion, deeth	plece, and	due to the cat the time, d	ause(s) and me ate and place,	enner es stat and due to t	ted. he ceuse(s)
ledina	legical	29e. Certifier 1 Certifyl (Check only one) 1 Medical	Examine	ctan: To the er: On the ba and mann	sls of examine	wledge, deat tion and/or In	vestigetlon,	in my o	pinion, deeth	plece, and	at the time, d	ate and place,	and due to t	he ceuse(s)
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polical	legical	29e. Certifier 1 Certifyl (Check only one) 1 Medical	er L	er: On the ba and mann	asis of examine ner stated.	tion and/or In	vestigetlon,	in my o	pinion, deeth	h occurred	at the time, d	ate and place,	and due to t	he ceuse(s)



State of Maryland / Department of Health and Mental Hygiene 9

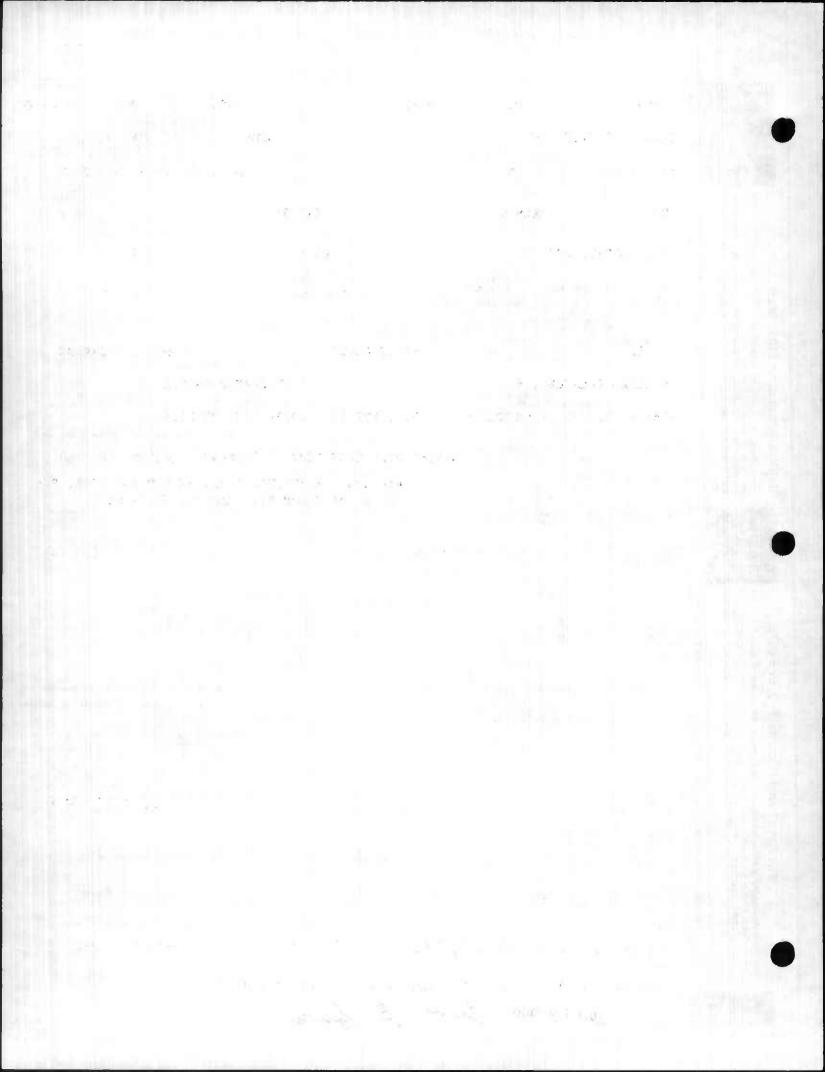
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month JAN. 15^{Dey} **Physician** HELEN F. SHARP 1999 10:26 PM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner TALBOT HOSPICE HOUSE EASTON TALBOT Birthplece (State or Foraign Country) 8. Dete of Birth (Month, Dey, Year) AUG. 25, 1 If Under 1 Yaar | if Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 1 ☐ M 2 🖾 F 83 Yrs 171-14-9171 1915 NEW YORK Director Usual Residence of Decedent death with the Meryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at MD TALBOT EASTON 1X Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 726 WAYSIDE AVENUE 21601 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American indien, Black, White, etc. 11 Merital Status filed within 72 hours after 1 Never Merried 2 Married 1 Yes 2 No Specify: altimore, Maryland 21215-0020 WHITE Specify: þ 3XXWidowed 4 □ Divorced Yaer or Dates: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) -0-SALES CLERK WOMEN'S CLOTHING 7 is marked other traumatic avent, 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Nem Z7 is marked oth any lojury or other traumatic avent pace. Be WILLIAM POLACHEK, SR. ELIZABETH WARHOL 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) JEAN A. LEONARD / DAUGHTER P.O. BOX 342, ROYAL OAK, MD 21662 20b. Pleca of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition Dete cemetery, cremetory or other place) 1 XBurial 2 Cremetion 3 Removal from State SPRING HILL CEMEETERY 1-18-99 4 ☐ Donetion 5 ☐ Other (Specify) EASTON, MD 21601 21. Signature of Funeral Service Lice Name end Address of Fecilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel 6 MO diseese or condition resulting in deeth) METASTATIC LUNG CANCER **Examiner** Due to (or es e consequence of) Examiner requires that the death certificate be executed physician and s the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): P.O. Box 68760, Physician/Medical Due to (or es e consequença of) Ses attending U\$8 Po been signed by the s should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings evallable prior to completion of causa of deeth? 24e. Wes en eutopsy Completed has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Attending Physician: director. 25. Wes case referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Kitcher (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No After this funeral 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. edical 29a, Cartifian To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) D0053602 JAN. 18, 1999 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) CAROLYN HELMLY, M.D., 606 DUTCHMAN'S LANE, EASTON, MD 21601 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

JAN 1 9 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 266 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1/19/99, bra, Talbot 2. Date of Death 3. Time of Death 1. Decedant's Nama (First, Middle, Last) STEDNITZ 18 1999 RICHARD JAN. 9:50 AM 4b. City, Town, or Location of Death 4c. County of Death

Amended #30, **Physician** /Medical Examiner **Funeral** Director the Maryland r 28a-f show Directo with r than "natural", or items 23a or the Medical Examiner must be r Pagas 1 and 2 should be filed within 72 hours after death nent of Haalth and Mental Hygiens.
Instit if Henry 27 is marked other than "natural", or items 23.
Inty or other traumatic event, the Medical Estating mainty or other traumatic events. Funeral altimore, Maryland 21215-0020 þ Completed Be Department of Important: If any injury or Physician /Medical Examiner

tha death cartificate be axecuted physician and the bunal-transit as t USa ŏ ed by the a that sign d be should I Wel cartificata has t lirector, paga 2 s Tha this funeral Affer Attending daath. actor: / 6 Dirac To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in b.

Box 68760 P.O. Records, Completed Division of Vital Be 10 Certification:

RAYMOND 4a Facility Name (If not institution, give street and number) 25906 MILES HAVEN DRIVE NEWCOMB If Under 1 Year | If Under 24 Hrs. Birthplace (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 18 M 2□ F Months Days Hours Min 79 Yrs. 158-10-7118 NOV. 6, 1919 NEW JERSEY Usual Rasidance of Dacedent 10a. Stata 10b. County 10c. City, Town or Location MD TALBOT NEWCOMB 10g. Citizen of What Country? 10e. Street and Numbar 10f. Zip Coda 25906 MILES HAVEN DRIVE 21653 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. tXYas 2 □ No If Yas, Giva Yaar or Datas: 1 □ Navar Marriad 2 □ Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3€Widowed 4 □ Divorced 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) Elementary/Secondary (0-12) Collega (1-4or 5+) 10 -0-CONTRACTOR HOME CONSTRUCTION 18. Mothar's Name (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) CARL STEDNITZ HELENE LOCKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) ESTHER R. MONTGOMERY 12340 QUINCE VALLEY DRIVE, NORTH POTOMAC, MD 20878 20b. Place of Disposition (Nama of cematary, cramatory or other place)
WILLIAM C. COYLE VETERAN
MEMORIAL CEMETERY 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 X Burial 2 Cramation 3 Ramoval from Stata 1-22-99 ARNEYTOWN, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility CESEFELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. LUNG CANCER Immediata Causa (Final disaasa or condition rasulting in death) Examin Sequentially list conditions, if any, laading to immediata causa. Enter Undarlying Causa (Disaase or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Physician/Medical Due to (or as a consaguanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown P

24b. Wara autopsy findings available prior to 24a. Was an autopsy complation of cause of death? 1 Yas 2 No 1 Yas 2 No 25. Was cesa referred to medical examiner? 26. Place of Daath (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 1 👺 Certifying Physician: To the best of my knowledge, beath occurred at tha tima, data and place, and due to the causa(s) and manner as stated. 29a. Cartifiai

2 Medical Examiner: On the pass of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) (Check only one) 29c. Licansa number

29b. Signature and title of certifian

29d. Date signed (Month, Day, Year)

10d. Insida City Limits 1 ☐ Yas 2 ♥ No

Approximate Intervai Between Onsat and Death

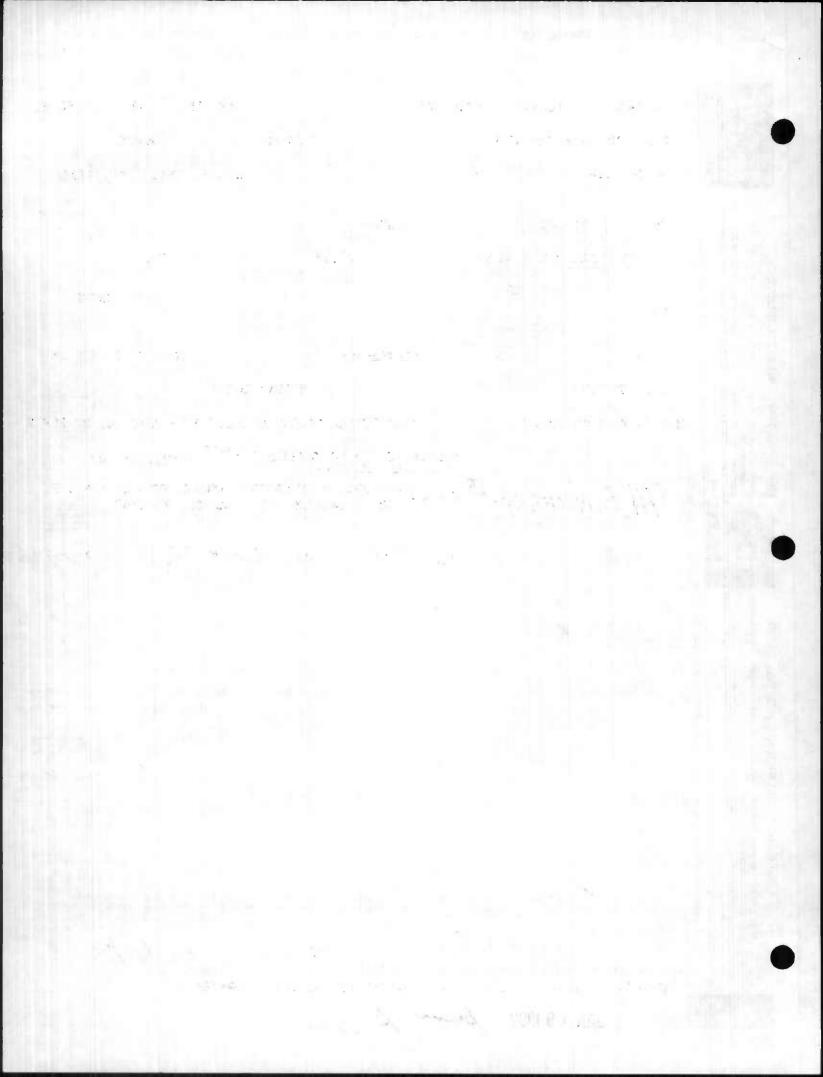
MONTHS

4

On Name and address of person who complated causa of death (tem 23a) (Type Print)
Daniel E. Makas, D.O., 508 Idlewild Avenue, Easton, MD 21601
PANIEL E. MAKAS, D.O., 508 IDLEWILD AVENUE, EASTON, MD 21601 31. Date filed (Month, Day, Year)

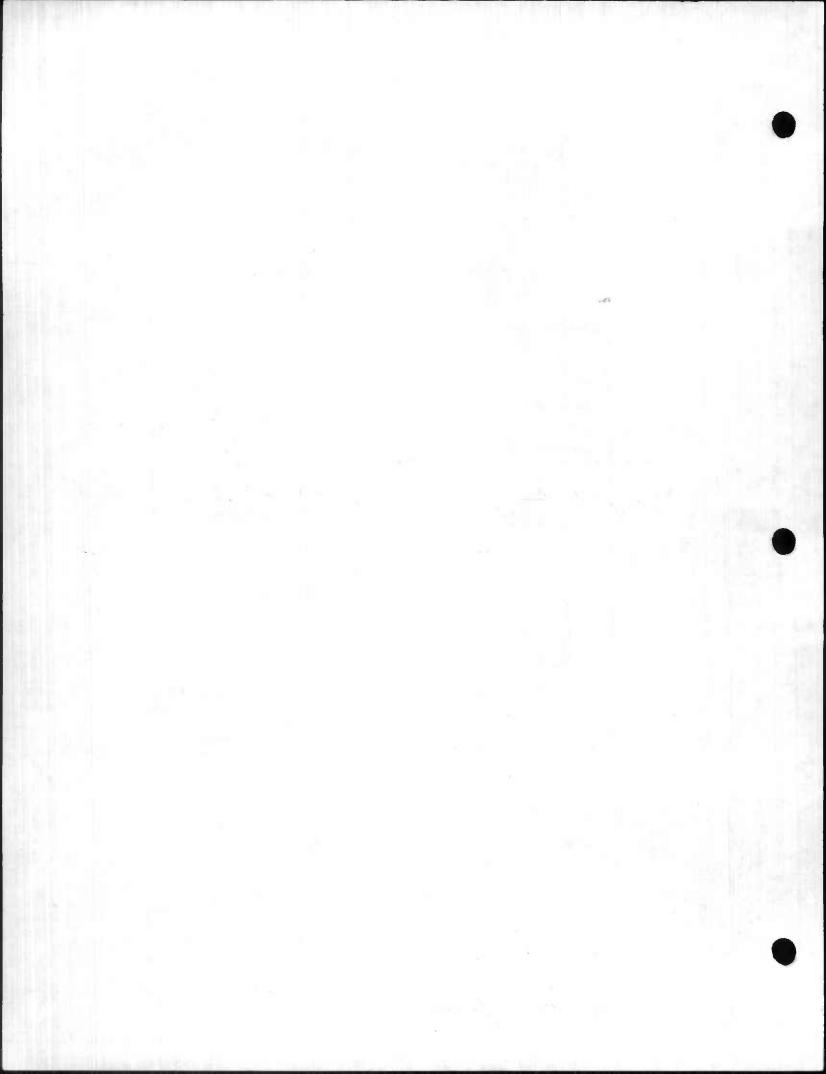
State Registrar

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 6 6 2

			Ce	rtificat	e of	Death			Reg. No.		(V	0 6-
lhuninian.	1. Decedent's Neme (First, Middle, Last)						i	2. Dete of Dee	eth Day	Yeer	3. Tim	e of Death
hysician /Medical	Dudley K. Ta	it						Januar	ry 16,	1999	7:	30 AM
Examiner	4a Fecility Neme (If not institution, give stre	et and number)				4b. City, To	wn, or Lo	cation of Deeth	4c. Cour	ty of Deeth		
	Suburban Hospital					Bethe				ntgome	4	do a
eral	5. Social Security Number 6. Sex	-300 -	n yrs. last birthday)	If Under Months	1 Year Deys		24 Hrs. Min.	8. Dete of Birt (Month, Da) Jan. 2	h y, Year)	9. Birth	piace (Sta	te or Foreig
or	088-20-0167	/	73 Yrs.					Jan. 2	1925	Mass	achu	setts
	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation						T	10d. Insid	e City Limits
ò	Maryland Montgomer			hesda								Yes 2K) No
Directo	10e. Street and Number	. 9	Det	10f. Zip			_		10g. Citizen o	f What Cou	ntry?	
	9226 East Parkhill	Drive				20814	4		United			
eral		Wes Decedent Ever	r in U.S. 13.	Wes Deced	dent of			ecity Yes or No- Rican, etc.)		ece - Ameri		٦,
Funer		Armed Forces? 1 ☐ Yes 2 ☒ No						Rican, etc.)	В	leck, Whita,	etc.	
à	3 Widowed 4 Divorced	If Yes, Give Year or Detes:	100	1□ Yes	2⊠ No	Specify:			Spec	wh:	ite	
8	15. Decedent's Educati		16a. Dece	dent's Usue	ol Occu	pation	a of words		16b. Kind ol	Business/In	dustry	
Completed	(Specify only highest grade co	College (1-4or 5+)	life.	DO NOT us	se retire	during mos	it of works	rig				
Ę	12		H	omema	ker				Own Ho	me		
Be	17. Father'a Nama (First, Middle, Last)					18. Moth	er's Name	(First, Middle,	Meiden Sum	eme)		
2	John Alden Kenyon					Ine	es Du	ıdley				
	19e. Informant'a Neme/Reletionship (Type,	Print)	19b. Meili	ng Address	(Stree	t end Numb	er or Rure	al Route Numbe	er, City or Tov	m, Stete, Zij	p Code)	
	Andrew Tait/Husband					rkhill	l Dri	ve, Bet				
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Rem		20b. Place of Dispo cemetery, cre	osition (Nan metory or o	ne of ther ple	ece) Ian	20	Date 1999	20c. Locatio	n - City or T	own, State	8
	4 ☐ Donation 5 ☐ Other (Specify)		Montgome						Bethes	da, M	aryla	and
	21. Signeture of Funerel Service Licensee		Ro	Name an	d Addr	ess of Fecili	rev	Funeral	Home/	Bethe	sda-(hevv
	Kant Jank	M	100108 /	55/ W	isc	onsin Maryl	Aven	lue		C	hase	, Inc.
	23a. Part 1. Enter the disease, or complicate shock, or heart feilure. List only one of	ions that caused the	death. Do not en	ter the mod	le of dy	ing, such as	cardiec	or respiretory er	rest,	1	Approxi	mate Between
	sition, of float foliate. Est only one of	Jacob Off Gaori Milo.								1	Onset a	ind Deeth
	Immediete Cause (Finel disease or condition	Liver	Cancer								week	S
	resulting in death) a	Due	e to (or es a conse	quence of):						1		
Examiner										1		
7	Sequentially list conditions,	Due	to (or es e conse	quence ol):								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events											
edical	that initieted events reaulting in death) Last	Due	to (or es e consec	quence of):								
Σ	d											
clar								1				
ysi	Pert II. Other significant conditions contrib	outing to death but no	ot resulting in the u	inderlying c	ause g	iven in Pert	I.		obacco uee			
P	Renal Failure, Pneu	monia, At	rial Fib	rilla	tio	n		10	Yes 2 N	3 □ Pro	bably	4 🔯 Unknow
Completed by Physician/								24a Wes	en eutopsy	24b. W	Vere eutor	osy findings rior to
lete	Hepatic Insufficien	cy, Aspir	ation					perfo	med?	C	ompletion	of cause
d L											deeth?	
									res 2□No	1	☐ Yes	2IXI No
o Be	25. Was case referred to medical examiner?	pitel:	-51-010		. 0	ther		h (Check only o			w 1	
: To	I Hes ZIZINO	1 🖾 Inpatient	2 ER/Outpatie		28c. Inju	7 🗆 14		me 5 Residente la			ity)	
tlon	in a still a s	28a. Date of Injury (Month, Day Ye	sar) Injury	м		ork? ∃Yes 2⊟						
Certification:	a Could not be	28e. Place of Injury -	- At home, ferm, st		v. office			28f. Location (S		mber or Rui	rel Route	Number,
en	4 Homicide	28e. Place of Injury - building, etc. (S	Specify)					City or Tov	vn, Stete)			
<u>a</u>	29a. Certifier 1 Certifying Physicia	an: To the best of m	y knowledge, deat	h occurred	et the t	ime, date er	nd place,	end due to the	ceuse(s) end	menner as	stated.	
edical	(Check only 2 Medical Examiner: one)	On the basis of exa and manner stated		vestigation	, in my	opinion, dec	eth occurr	red at the time,	dete end pled	e, and due	to the ceu	ise(s)
ž	29b. Signeture end title of certifier	7	1	290	. Licen	se number			29d. Date sig	ned (Month	Dey, Yea	Br)
	R. M.	Locano	Mb]	001191			Januar	y 16,	1999	9
	30. Name and address of person who comp	leted cause of death	(Item 23a) (Type	Print)								
	Ralph M. Coan, M.D.		lver Str		Ken	singto	n. M	arvland	2089	5		
ate	31. Date liled (Month, Day, Year)	32. Registrar's		,	1							
trar	JAN 2 1 1999	y Dene	we to	. 1	one	Kal						

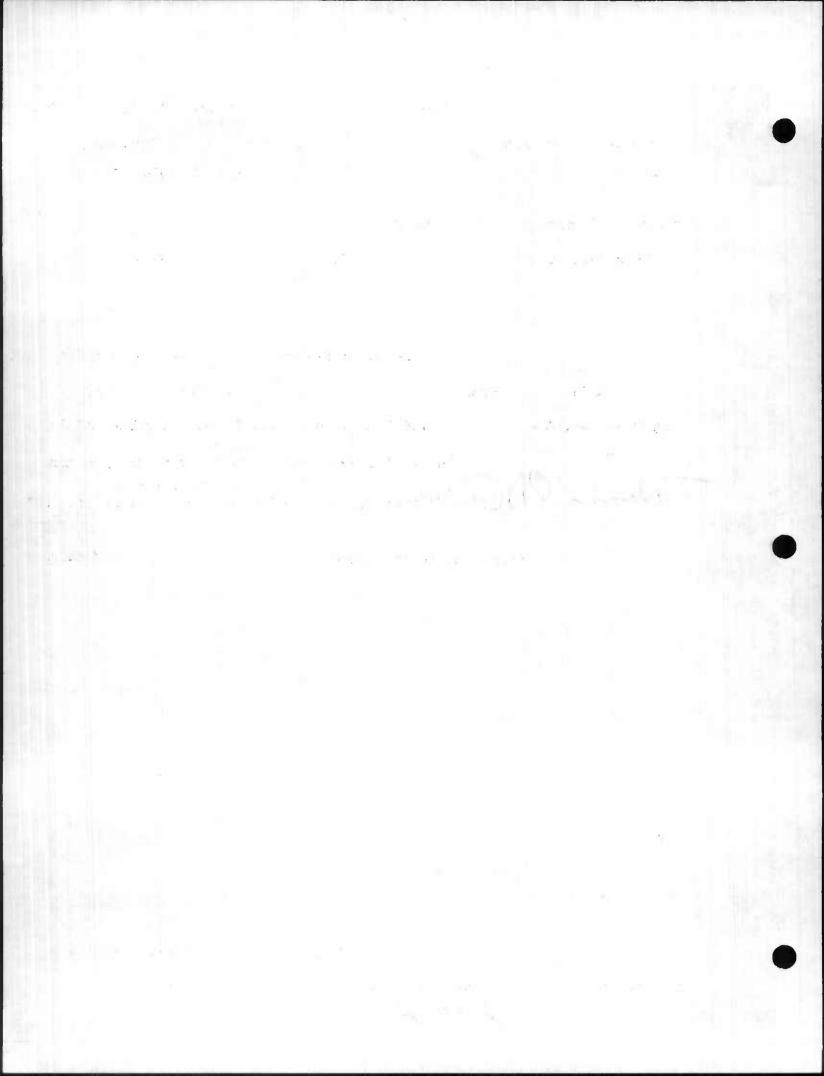


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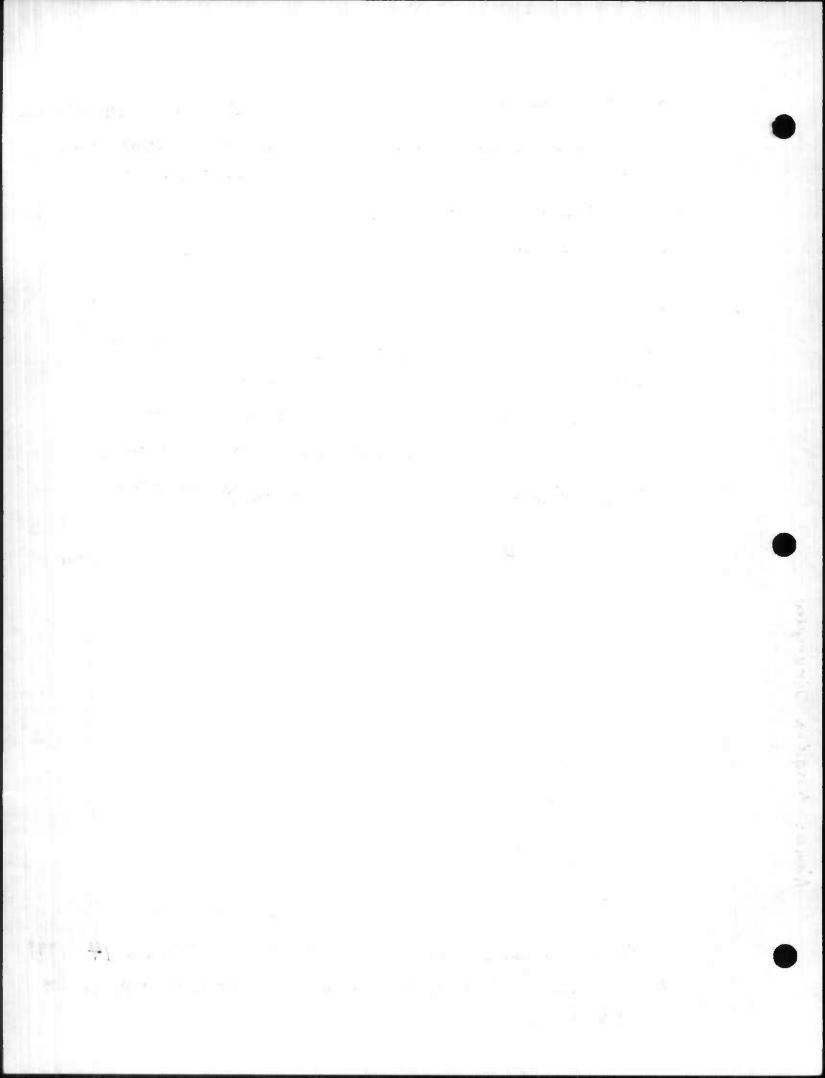
/sician	1. Decedent's Neme (First, Middle,	Last)					2. Dete of Dee Month	th Day	Yeer	3. Time of Deeth		
	Tin-Yu	ian	Tan	Q			January		1999	12:30 A		
edical miner	4e Fecility Name (If not institution, g				4b. City		ation of Deeth					
	10813 Maplecres	st Lane			P	otomac		Mon	tgome	rv		
			ge (In yrs. lest		er 1 Year If Un		8. Dete of Birtl (Month, De)			ace (Stete or Fore		
	212-51-1604 Usuai Residence of Decedent	1⊠M 2□F	82	Yrs. Months	Days Hou	rs Min.	July 29	, 1916	Chi	na na		
	10e. State 10b. County		10c. City, T	own or Location					10	d. Inside City Lim		
lo	Maryland Montgo	Nm0 237	Po	tomac						1 ☐ Yes 2 🖾 !		
Director	10e. Street and Number	лиет у	110		ip Code			10g. Citizen of V	Vhat Count	ry?		
	10012 Manlagen	t Tama			20854			Chir				
era	10813 Maplecres 11. Meritel Stetus	12. Was Decedent	Ever in U,S.		edent of Hispanic ecify Cuban, Mex	Orlgin? (Spe	cify Yes or No-		e - America			
by Funeral	1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Yeer or Detes:			ecify Cuban, Mex 2 No Spec		Rican, etc.)	Specify:				
2	15. Decedent's		1	6a. Decedent's Us	ual Occupation			16h Kind of Bu	ASI			
Completed	(Specify only highest	grede completed)		(Give kind of w	ork done during r	during most of working d)		16b. Kind of Business/Industry		uotiy		
E	Elementary/Secondary (0-12)	College (1-4or	5+)						ublic of China			
	17. Fether's Name (First, Middle, La	st)		Governme		-	Republic of China Name (First, Middle, Meiden Sumeme)					
Re												
10	Y1-Fu 19a. Informant's Name/Relationship	Tang		19b. Malling Addre	on (Chanata and Ma	mharas Dissa	Wen-H		Tai			
	Jang-Shien Tang/ 20e. Method of Disposition	Son		10813 Map				20c. Location -				
	1 Burial 2 TCremation 3	☐Removal from State	com	etery, crematory or	other placa)		an 26	200. Location -	City of Tot	WII, State		
	4 ☐ Donation 5 ☐ Other (Spe	cify)	Metro	opolitan	Cremato	су	1999	Alexand:	ria,	Virginia		
-	21. Signature of Funeral Service Lic	censee) \	'00	22. Name a	and Address of Fe	ocility	Vol Fu	neral Ho	nme			
	Michan	X1)(91	lele a	WILL FOR	t Door E					MD. 208		
iner	Immediate Cause (Final disease or condition resulting in death) a Congestive Heart Failure Due to (or as a consequence of):											
edical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events Due to (or as a consequence of):											
460												
clai	David Other deathless as a date					1	ant Dula			Abo serves of des		
S	Part II. Other significant conditions	contributing to death t	out not resultin	ng in the underlying	cause given in P	art I.				the cause of dea		
2							1 1 1	Yes 2 No	3 Prob	ably 4 Unkn		
by									T			
by								an autopsy med?	cor	re eutopsy finding Ilable prior to oppletion of cause Jeath?		
by								med?	cor of o	plable prior to		
le Completed by Physician/A	25. Was case referred to medical				26 P	lace of Death	perfo	med?	cor of o	llable prior to apletion of cause leath?		
o Be Completed by	examiner?	Hospital:	ent 2∏FR	W∩utnationt 3□ I	Other		perfo	med? (es 210 No	ave cor of c	Illable prior to appletion of cause leath? Yes 2 No		
lo Be Completed by	examiner? 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending	28a. Date of Inju		I/Outpetient 3□ I Bb. Time of Injury	OOA Other: 4 [28c. Injury at Work?	Nursing Hon	perfo	med?	ave cor of c	Illable prior to appletion of cause leath? Yes 2 No		
To Be Completed by	examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ary Yeer) 28	3b. Time of	OOA Other: 4 □ 28c. Injury at Work? 1 □ Yes 2	Nursing Hon	(Check only one 5 \$\mathbb{B}\$ Resides Red. Describe h	rmed? Yes 235 No Yes 275 No Yes 6 □ Oth How Injury occurs Street and Numb	ave cor of c	llable prior to moletion of cause leath? Yes 2□ No		
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Physic /Medi Exami	ian		a (First, Middle, La	*					2. Date of D			3. Tima of Death	
		Angela	Mary Tr	umpler					Jan	Day [U	Year Q Q	8:35 au	
STATE OF THE PARTY NAMED IN		4a. Facility Name (f	f not institution, give	a street and number)				4b. City, Town, or	-		y of Death	V (M	~
		Cha	x lestow.		Cent	ter		Caton			ultin	norl	
Funeral Director		5. Social Sacurity N 220-14-92		ex	a (in yrs. iast t	Yrs. If Un Monti	hs Da		8. Data of B (Month, I May 15	irth Pey, Year) , 1916	9. Birthp Coun MD	iace (Stata or Foreigr try))
and		Usuai Rasidance of 10a. Stata	10b. County		10c. City, To	wn or Location					11	0d. Insida City Limits	-
e Maryl Ba-f sho	Director	Md	Baltimor	е	Balti	more						1 ☐ Yas 2 XNo	
and 21215-0020 be filed within 72 hours after death with the Maryland hall hydiena. d other than "natural", or items 23s or 28s-f show event, tra Medical Examine must be notified at		719 Maide		Lane			Zip Cod 1228			10g. Citizan of USA	What Coun	itry?	
or items	Funeral	11. Marital Statua 1 Navar Marri	ad 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yas, Giva				of Hispanic Origin? (S Cuban, Maxican, Puer	Specify Yes or Note Rican, atc.)		ce - Americ ick, Whita,	atc.	
hours turns!	ed by	3 ₩ Widowed	4 Divorced	Yaar or Datas:			s 2XII			16b. Kind of E	y:whit		
Maryland 21215-0020 d 2 should be filed within 72 hours aff th and Mantal Physiena. 7 is marked other than "natural", or traumatic event, tra Modical Exam	Completed	(Spec	ify only highast gre	da complated) Collega (1-4or 5-	+)	(Giva kind of life. DO NO meat p		cupation ona during most of wo tired)	orking	Esskay		1111	
other cent, u	Be Co	17. Father's Nama ((First, Middla, Last)				-	18. Mothar's Na		a, Maidan Sume	me)		_
nylar nould by Manta mrked	ToB	William							Murphy			. 20	
Main and 2 st and 2 st and 2 st and 2 st and 2 st and 27 ls m		William		(son)	1	003 Bru	ice (Str	ct., Sykes	ville,	MD 21784), Steta, Zip	Code)	
Baltimore, Maryland 21215-0020 pemit. Pages 1 and 2 should be filed within 72 hours aftar. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural, or ite any injury or other traumatic event, the Medical Examina once.		20a. Mathod of Disp 1 Durial 2 4 Donation		Ramoval from Stata		of Disposition (i lary, cramatory of atheora			Data -18-99	20c. Location Baltimo			
Balti permit. Department any inju		21. Signature of Fu	naral Sarvica Licen	Harlt		22. Nama	a and Ad	tdress of Facility H 195 Sykes	aight F	uneral F MD 21784	Iome &	Chapel	
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Physician /Medical		Immediate Causa (Final	£ . 1	-1						į	Onsel and Death	
Examiner		disease or condition rasulting in daath)	n	a. End		consequence		entia			i	years.	
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58760, icate be avecuted physician and s the bunal-transit	al Ex	Sequentially list cor if eny, laading to im cause. Enter Unde Cause (Disaasa or that initiated eyants	madiata rtying injury	C							İ		
- D 6	/Medical	resulting In death) L		d	Dua to (or as a	a consaquence o	of):						
daath cert a attending d for usa a	ician	Part II. Other algorifi	cant conditions o	ontributing to death bu	t not resulting	In the underlyin	on collec	given in Part I	23h Die	t tobacco una c	ontribute to	the cause of death?	2
P.O. that the ed by the detache	/ Physician/N	Tarrii Ottor argini	outil Collections of	minibuling (O death bu	t not resulting	iii tila undanyiii	ig cause	givan in Fait i.		Y•• 2□Wo		bably 4 Unknow	
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Division of or Attending Fatter death. Director: Atter	Certification:	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicida	5 Panding Invastigation 6 Could not be	(Month, Dey	Year)	Injury M		njuryat Work? 1 □ Yas 2 □ No					
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To the Hospital within 24 hours a To the Funeral Complataly filled	edical	29a. Certifier (Check only one)	1 ☐ Certifying Phy 2 ☐ Medicat Exam	rstcien: To tha bast of Iner: On tha basis of and manner stet	axaminetion a	ge, deeth occurr ind/or Invastiget	red at the tion, In m	a tima, data and place ny opinion, deeth occ	e, and dua to the urred et the time	a causa(s) and m o, dete and piece	anner as st , and dua to	teled. tha cause(s)	
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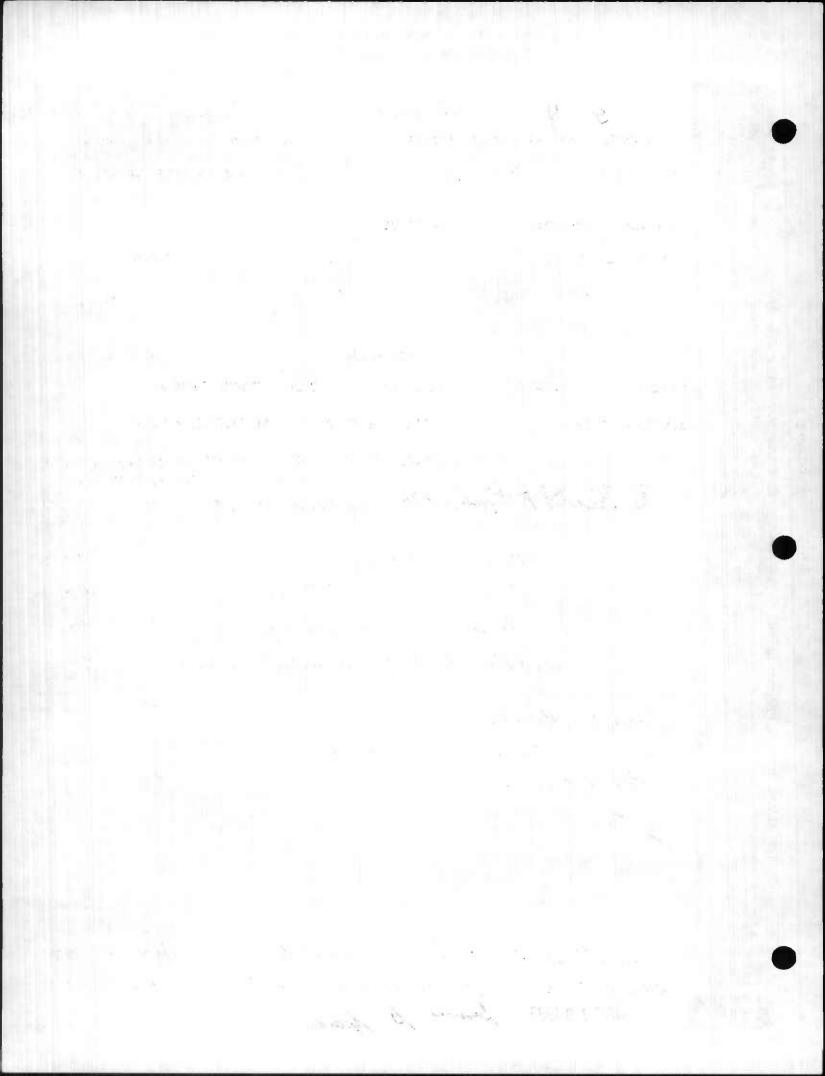


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									Reg. No.	
Physician-	1. Decedent's Nar	me (First, Middle,	, Last)	7/1				2. Dete of De Month	eath Dey	3. Time of Dea
/Medical	Bet	tey	4.	Tre	herne.			JAnu	ansi	999 150
Examiner			eve street end num			1		r Location of Deat	h (c. County	of Death
	PENINS	ULA REGI	ONAL MEDI	ICAL CEN				SBURY		VICOMICO
Funeral	5. Social Security	Number	6. Sex 1 □ M 2 F	7. Age (In yrs. la	Mont	ths Deys	If Under 24 H Hours Mi		th ay, Year)	Birthplace (State or Fo Country)
Director	270-14-30		10 W 20 F	80	Yrs.			AUG.23	,1918	OHIO
	Usuel Residence	of Decedent 10b. County		10c City	. Town or Location					10d. Inside City L
28a-f show coffined at	Toa. State	100. County		roc. Ony,	, TOWN OF LOCATION					1 ☐ Yes 2 Å
28a-1 sho	MARYLAND	*	MICO	SAL	ISBURY					1114121
me 23e or 28e-1 show mant to motified at neral Director	10e. Street and No	umber			10r.	. Zip Code			10g. Citizen of 1	
23a	410 PINE	BLUFF	RD.			218			U.S.A	
	11. Marital Status		Armed For		if Yes,	ecedent of F specify Cubi	lispenic Origin? an, Mexicen, Pu	(Specify Yes or No arto Ricen, etc.)	Bla	ce - American Indian, ck, White, etc.
0 5		rried 2 Marrie	If Yes, Giv	/ 0	1□ Ye	s 2 No	Specify:		Specif	WHITE
'natural', police Ex	3 Ll Widowed	4 Divorced	Year or De	eles:					40) 10)-1-4 D	
- 30 - 9	(Spe	15. Decedent's ecify only highest	s Educetion t grade completed)		16a. Decedent's L	work done	during most of w d)	rorking	16b. Kind of B	usiness/Industry
than the control of t	Elementary/Sec	condary (0-12)	College (1	-4or 5+)			0)		OTTO	HOMB
Hygien then the mut, the	12 17. Falher's Name	Circl Middle I	i anti		HOMEMAI	KEK	10 Methode N	ame (First, Middle		HOME
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t Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me To Be Compi	19a. Informant's h							Rural Route Numb		
of Health and Mental Hygin Hem 27 is marked other other traumatic event, I	ALFRED D		CNE		410 PINE ace of Disposition		KD. S	ALISBURY		
T to T	20a. Method of Di 1X Burial 2	•	3 Removel from S	State	metery, crematory	or other pla		Date	20c. Location	- City or Town, State
Department of Important: If it any injury or or once.		5 ☐ Other (Sp		WICO	MICO MEMO	ORIAL	PARK	1-20-99	SALISBU	JRY, MARYLAND
Depenti Importi any Inj pnce.	21. Signature of F	uneral Service L	icensee A	1	22. Name	e and Addre	ss of Facility		705 E. N	MAIN ST.
Depe Impo	1 K	Keil	X M	ma C	FSP -			01/77 7110	0.17.707	11771 MD 0100
	23a. Part1. Enter	the disease, or o	complications that conty one cause on e	eused the death.	. Do not enter the	mode of dyli	INEKAL H	OME, INC.	SALISI arrest,	BURY, MD 2180
hysician	shock, or he	art failure. List o	only one cause on ea	ach line.			_			Interval Between
/Medical										Onset and Dee
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xaminer	Immediate Cause disease or condit resulting in death	ion	a. Puln	nenavj	Edem					Onset and Dee
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BELLE TRENERAE

DHMH 16 Rsv 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month Day **Physician** January 15, 1999 8:45 AM Elgie J. Underwood, Jr. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year)
April 20, 1913

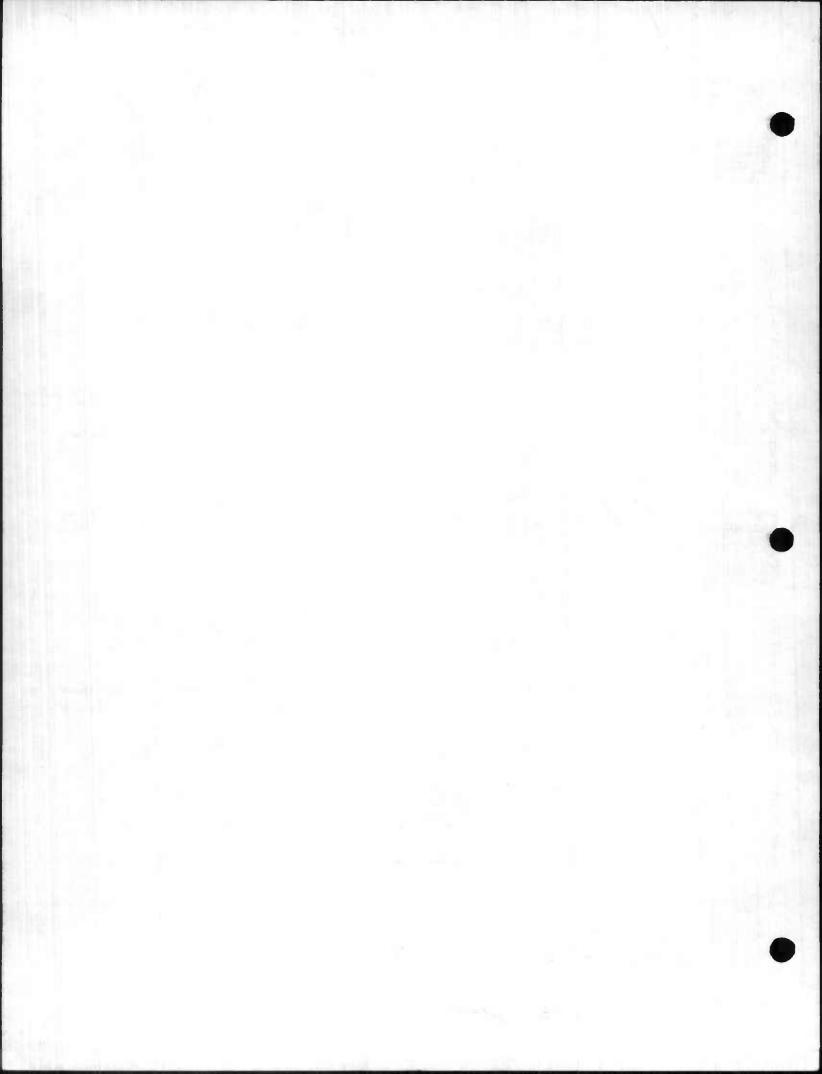
9. Birthplace (Stata or Fo Country)
Pennsylvania 5. Social Sacurity Number Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2□ F 210-10-9556 85 Yrs. Director Usual Residence of Decedant 10b County 10c. City, Town or Location 10d. Inside City Limits with the Marylar 28s-f show Bethesda 1 □ Yes 2 K No Maryland Montgomery Director 10e Street and Number 10f. Zin Code 10g, Citizen of What Country? thems 23a or 20814 United States 5804 Kingswood Road Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 □ Yas 2 ② No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yas 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Montgomery County Elementery/Secondary (0-12) Cottega (1-4or 5+) 5+ Public Schools Teacher Specialist 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Itam 27 is marked oth any Injury or other traumatic event Be Mary McDonald Elgie J. Underwood 0 19a. Informant's Name/Ratationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 42 Fairhaven Rd., Tracys Landing, Maryland 20779 Mary Underwood Trudo/Daughter 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stata 20a. Mathod of Disposition cematary, crematory or other place) Jan. 18, 1 ☐ Buriai 2 ☑ Cramation 3 ☐ Ramovai from Stata Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licensee Robert A. Fumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Chase, Inc. Bethesda, Maryland 20814-3501 M00198 duess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Enter the Approximate Intervat Between Onset and Death **Physician** /Medical Immediata Causa (Final 1 Hour Myocardial Infarction disaasa or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner Arteriosclerotic Cardiovascular Disease The lew requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated avants rasulting in daath) Last burial-trer Dua to (or es e consequence of): P.O. Box 68760. physician s the buria Dua to (or as a consequence of): 88 USB been signed by the a should be detached Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 Probably 4 Unknown Records, à 24b. Ware autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 ₺ No 1 ☐ Yes 2 ☐ No certificate of Vital Hospital or Attending Physician: director, 25. Was casa referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 27. Mennar of Death 28a. Dete of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending invastigation 1 Naturai death. 1 Yes 2 No 2 Accidant within 24 hours after death To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 ☐ Could not be datarmined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) edicai 29a. Certifier To the 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year) 15 D01120 January 16, 1999 30. Nama and address of person who complated pause of death (Neph 23e) (Type, Print)
Walter Goozh, M.D. 1299 Lamberton Drive, Silver Spring, Maryland 20902 31. Data filed (Month, Day, Year) 32. Pegistrar's Signatura State

DHMH 16 Rev 6/95

Registrar

JAN 1 9 1999

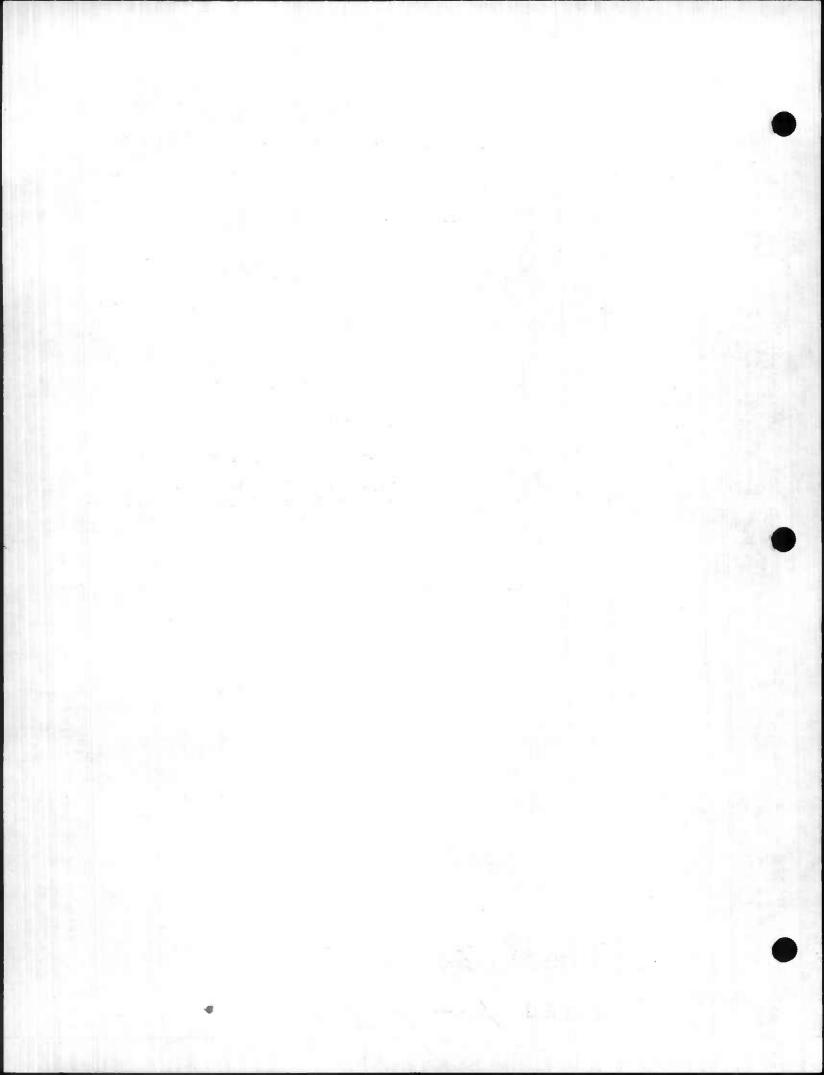


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State of Maryland / Department of Health and Mental Hygiene

	Decedant's Neme (First, Middla, La:	ot)		Centit	icate of	Death	2. Data of D	Reg. No. G	0256	7		
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/Medical		Luciel	1.	2.0	Vau	ghan	Januar	-		08 PM		
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rector		□ M 25χF	101		onths Days				9. Birthplace (Stata Country) Wisconsin	l roreign		
14	10a. Stata 10b. County		10c. City,	Town or Location	on		7011		10d. Inside C	City Limits		
one must be notified at	Maryland Montgome	ery	Roci	kville					1 🗆 Yas	2 No		
Director	10e. Street and Number			1	Of. Zip Code			10g. Citizan of V	What Country?			
la I	11608 West Hill	Drive			20852	2		United :	States			
by Funeral	11. Meritel Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yas 2 ☑ N If Yas, Giva Yaar or Dates:			Decedent of s, specify Cult		(Specify Yas or Nearto Rican, etc.)		e - Amarican Indian, ck, Whita, atc.	H		
8	15. Decedant's Ed	lucation		16a. Decedant	's Usual Occu	pation			usiness/Industry			
Completed	(Specify only highest gra	da complated) Collega (1-4or 5	4)	(Giva kind lifa. DO l	f of work done NOT usa retin	during most of v	vorking					
E	Liamentary/Secondary (0-12)	2	"	House	wife			Own Hor	me			
Be	17. Fether's Nema (First, Middla, Last)					18. Mother's N	lama (First, Middle	a, <i>Maidan Sum</i> am	ia)			
0	Christian Edwar	d Elliger	ı			Thoma	sine Pr	ideaux				
	19a. Informant's Neme/Relationship (Type, Print)		19b. Meiling A	ddress (Stree	t and Number or	Rural Routa Numb	ber, City or Town,	Stata, Zip Coda)			
	Martha Vaughan Or	loff (daugh			as 10							
	20e. Mathod of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐	Removal from State	20b. Plac	ce of Dispositionetary, crameto	on (Nama of ory or other pla	1ce)	Data	20c. Location -	City or Town, Stata			
	4 □ Donation 5 □ Othar (Specify	/)	Ches	sapeake	Crema	tory	1-22-99	Beltsvi	lle, Maryl	Land		
8500	21. Signature of Funarai Sarvice Licen	1. Kon	P	Rap 933	op Fune 3 Gist	Avenue,	vices, P.	Spring, N	MD 20910			
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	Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disease or injury that initiated evants	Arterio	scler	osis					old			
n/Medical	Cause (Disease of Injury that initiated evants resulting in death) Last	d	Dua to (or a	s a consequant	ce of):							
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by Physician/M							10	Yes 2□No	3 ☐ Probably 4 🖔	Unknow		
Completed							24a. Was	s an autopsy ormed?	24b. Wara autopsy available prior completion of of death?	to		
Сошр							1 🗆	Yas 210 No	1 ☐ Yas 2 🕅	No		
Be C	25. Was case refarred to medical axaminar?					26. Placa of C	Death (Check only	ona)				
	1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatia	nt 2 EF	NOutpatient 3	BOA O	ther: 4K Nursing	Home 5□ Ras	idence 6 Oth	er (Specify)			
5 2		28a. Data of Injury (Month, Dey Year) 28b. Time of Injury Injury			28c. Inju We M 1	ork? Yes 2 No	28d. Describe	how injury occur	fed			
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pletery filled in by the funeral di edical Certification: To	1 Action 5 Pending Investigation 5 Pendi	28a. Plece of Injubuilding, etc. yelclan: To the best of and manner ste	t my knowle axamination led.	edge, deeth occ n and/or invasti	courred at the tigation, in my 29c. Licen	ime, date and pla opinion, daath od sa number 31319	City or To	e cause(s) end ma data and place, s 29d. Data signed January	annar as stated. and due to the causal d (Month, Day, Year)			

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death Day January 12, 1999 4b. City. Town, or Location of Death 4c. County of Death Avenue #208 Gaithersburg | # Under 24 Hrs. | 8. Date | Hours | Min. | (Mo Montgomery 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) 1□ M 2⊠ F Months Days

2:35pm

10d. Inside City Limits

Approximete Intervel Between Onset end Death

years

2 ros p

20 P79

White

1 XYes 2 No

1. Decedent's Neme (First, Middle, Last) **Physician** Sophie G. Wagner /Medical 4a Facility Name (If not institution, give street and number) Examiner 101 Odendhal 5. Social Security Number **Funeral** Yrs. 76 Director June 17, 1922 Pennsylvania 166-14-2636 Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location item 27 is merked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at Director Gaithersburg Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 101 Odendhal Avenue #208 20877 United States pernit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If it sure 27 is marked other than "natural", or thems 23a any Injury or other traumatic event, in a Medical Exercise men. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: p 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hair Salon Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Frank Gomola Hedwiga Ceprish 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 9 Lee Avenue, Takoma Park, MD 20912 John W. Wagner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 N Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) St. Michaels Catholic Cem. 1/16/99 Snow Shoe Twp., PA 22. Name and Address of Fecility DeVol Funeral Home 21. Signature of Funeral Service Licens any l 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heeft failure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Child's class III Liver arrhosis Examiner Examiner Chronic Active ZHROASH attending physician and for use as the bunal-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 80 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin Dependent Diabetes, Chole lithiania Š 8 24e. Was en autopsy performed? Completed Esophageal various, Bronchactasis paga 2 Gastro esophageas Rettux 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes 2 No this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? Aftar 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 PNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier National Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Pa Duhar syon January 12, 1999 MA PP 714 a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. Callakan - Lyon, MD 911 Russell A

State Registrar

Medical

31. Dete filed (Month, Dey, Year) JAN 1 9 1999

911 Russell Ave Gailtersburg, mo 39. Registrar's Signature

DHMH 16 Rev 6/95

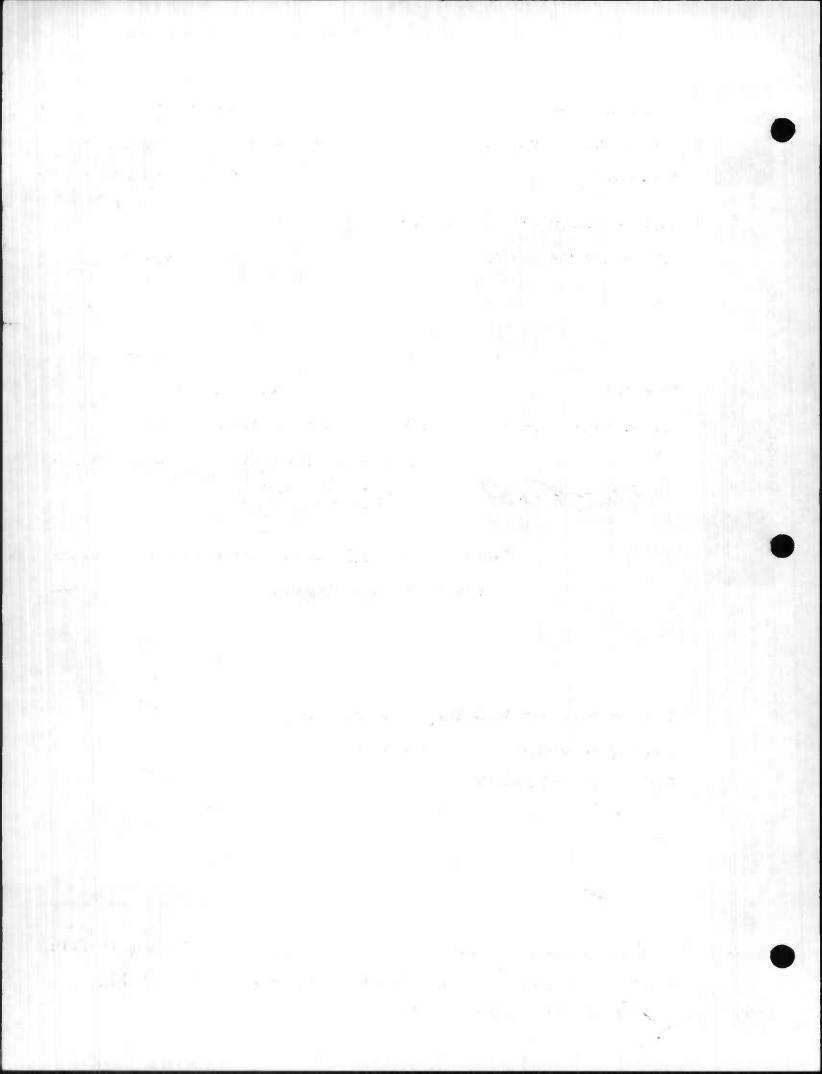
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/Medic Examir ——uneral		4a Fecility Name (If not institution, give POTOMAC VA) 5. Sociel Security Number 6. S		ALLE ESING rs. last birthdey)	CTR.	4b. City, Town, o. ROCK	Location of Deel	MON	1760	MER)	
rector		406-28-6484 Usual Residence of Decedent	□M 21XF 9:		Months Days	Hours Mir	s. 8. Date of Bi (Month, Do Oct. 3	l, 1907	Kent	v)	
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man matur	Completed	15. Decedent's Ed (Specify only highest green Elementery/Secondery (0-12) 1 2	ucation de com <i>pleted)</i> College (1-4or 5+)	16a. Deced (Give k life. D	ent's Usual Occup kind of work done O NOT use retiral	pation during most of wi d)	orking		Business/Industry Government		
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marked other	L C	D. W. Wallen				Girlie	(Unknow				
9 6		19e. Informant's Name/Relationship (7 Patricia Wilczek	(guardian)		g Address (Street					,	
Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Specify	20b Removel from State	. Place of Dispos cemetery, crem	ition (Neme of etory or other please National	ce)	Dete 1-22-99	20c. Location -	ockville, MD 20850 coation - City or Town, State cel, Maryland		
any Inj any Inj ance.		21. Signature of Funeral Servica Licens	Rapp	R	Name end Addre app Fune 33 Gist	ral Serv			MD 209	910	
	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. ———	(or as a consequ					7	8 HOU	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Veer **Physician** 12, 1999 Nadine Dale Ward January 4:35pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9210 Warfield Road Gaithersburg M If Under 24 Hrs. 6. Date of Birth (Month, Dey, Year) Montgomery 5. Sociel Security Number If Under 1 Yeer Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. lest birthday) **Funeral** Months Days 1□M 2XXF Director 73 579-28-9520 July 16, 1925 Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 7 is marked other than "nature!", or items 23a or 28s-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 Ñ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9210 Warfield Road United States

14. Raca - American Indian,
Black, White, etc. 20882 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White Aq 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural; any injury or other traumatic average." Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Russell Dale Cecile Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Debra Schmidt (Daughter) 9210 Warfield Road, Gaithersburg, MD 20882 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Djsposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 1/15/99 Silver Spring, MD
22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Drive Gaithersburg, MD 20877 n 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final PULLONAM EMPHY SEMA Lycas disease or condition resulting in death) Examiner Due to (or es e consequenca of) Examiner the bunel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): P.O. Box 68760, ettending physician for use es the bune Physician/Medical Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Tes 2 No 3 Probably 4 Unknown u LMON AMY EMBOUSM Records, P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen page 2 certificate has 1 ☐ Yes 2 2 1NO 1 □ Yes 2 □ No Division of Vital 25. Was case referred to medical Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 | Inpatient 2 | ER/Outpetient 3 | DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending Investigation To the Hospital or Attendif within 24 hours efter death. To the Funeral Director: Al completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the best of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

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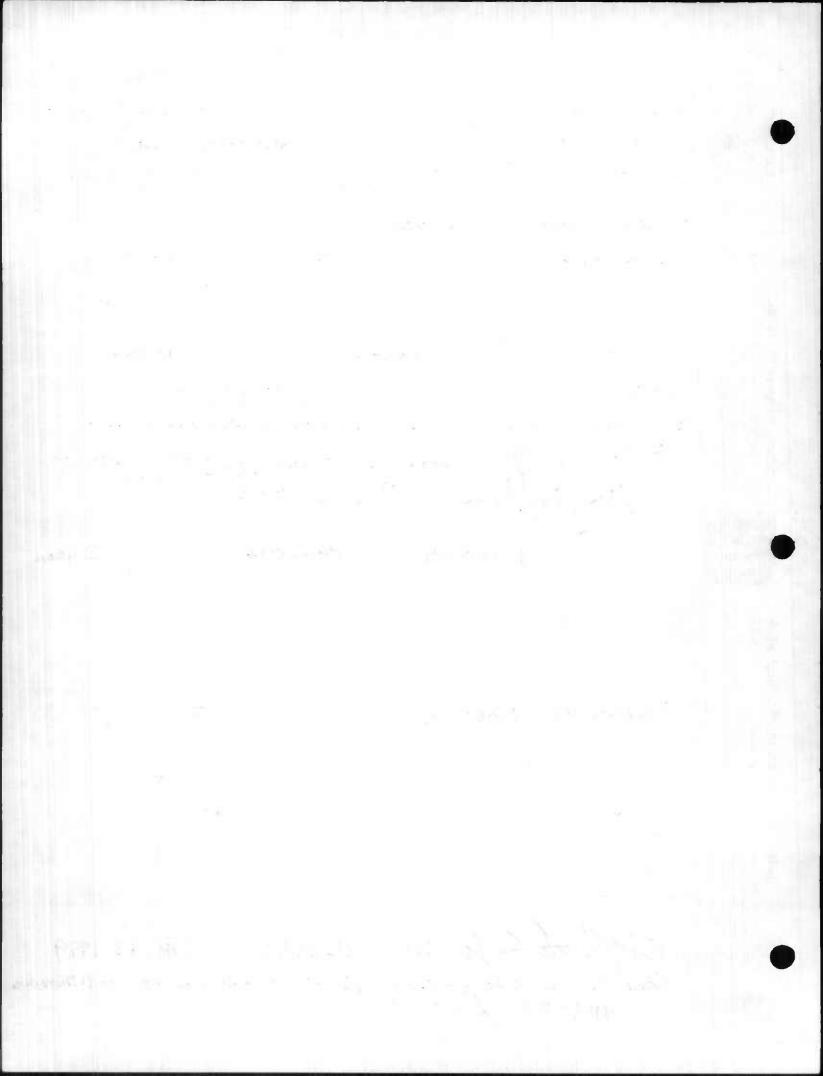
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Registrar

State

31. Date filed (Month, Dey, Yeer)

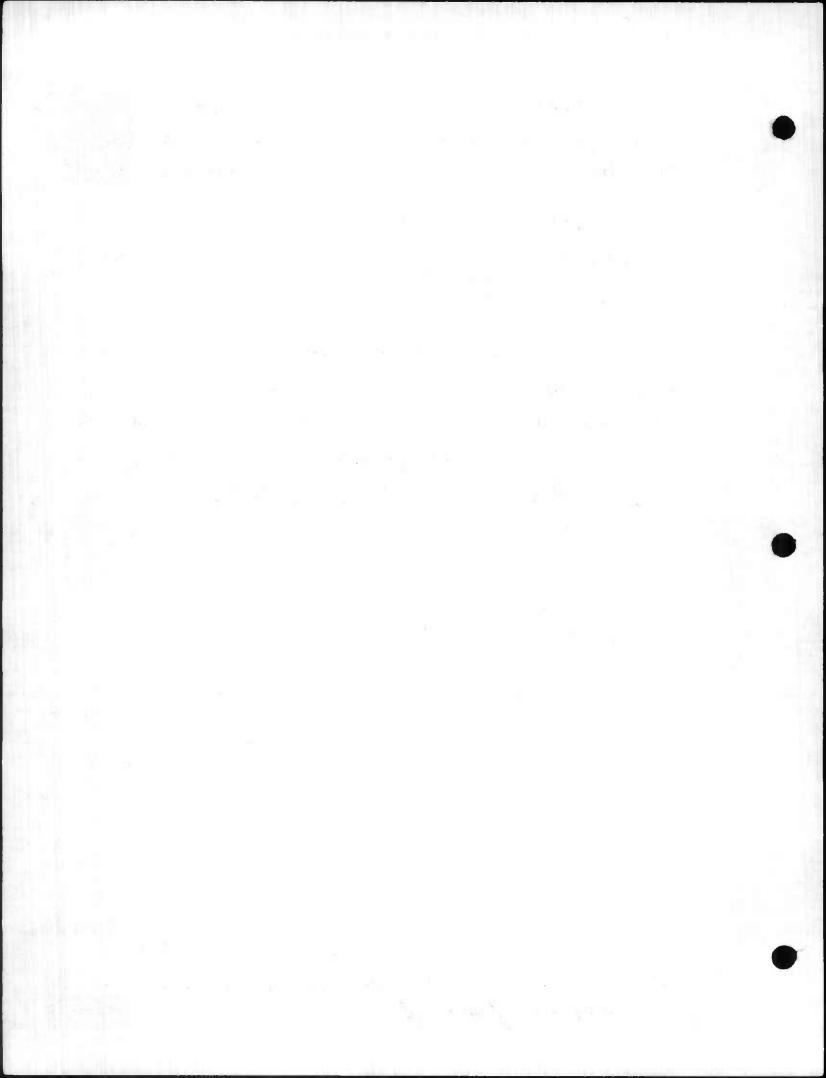
JAN 19



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Funeral Director		National Ins 5. Social Security Number 226-76-1007			last birthday) Yrs.	If Undar 1 Yaar Months Days		8. Data of Bir		2	nace (State or Foraig	
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Physician /Medical Examiner physician and physician street properties the prival-transit	al Examiner	Immediata Causa (Final disease or condition rasulting In death) Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a. Car b. Seps c. Alos	Dua to (o Dua to (o		ance of):	ymphoi	nA, DIS	sen t	MAI	72 hs	
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, 0		30. Nama and addraes of person \[\begin{align*} \text{\$O\$ & \$\beta\$ \cdot \\ \text{\$O\$ & \$\beta\$ & \$\delta\$ \\ \text{\$1\$}. Data filed (Month, Day, Yea, JAN 19	5 A 3			rint)	KE, BETH			(

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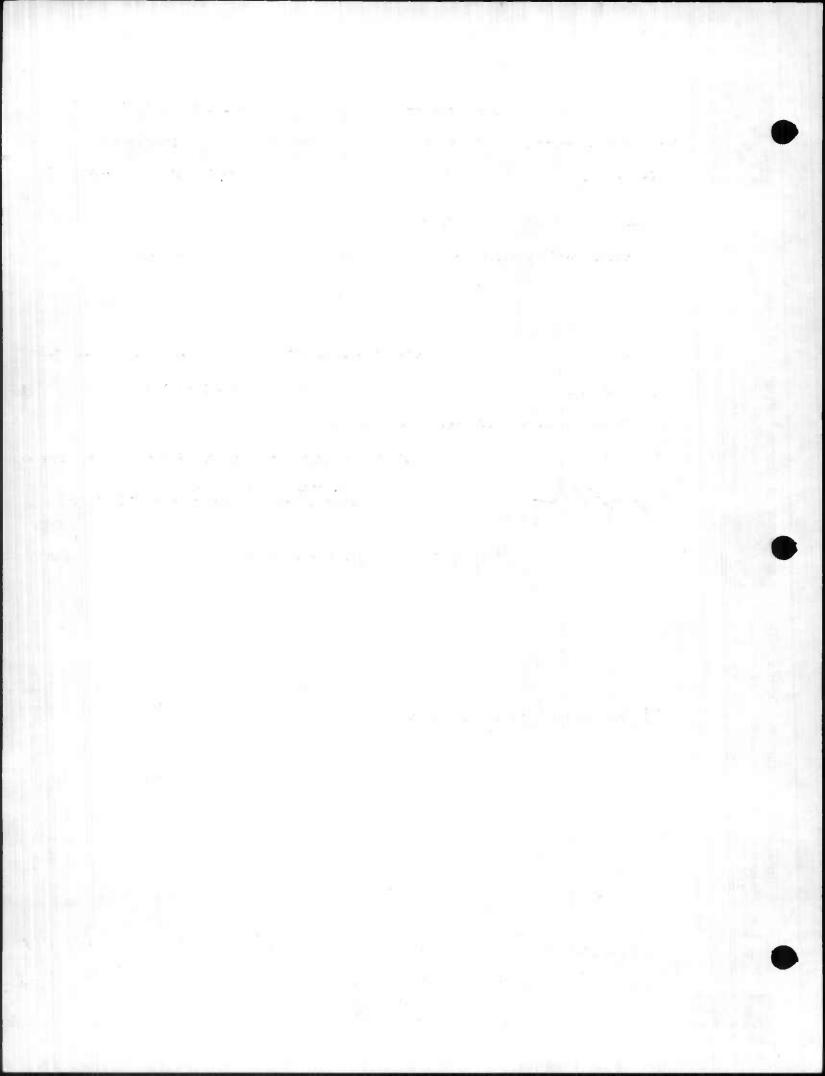


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State of Maryland / Department of Health and Mental Hygiene 99 02672

	Certificate of Death	F	leg. No.	02016						
	1. Decedent'a Nama (First, Middle, Last)	2. Date of Dea	ith	3. Time of Death						
Physician	Estella Eva Webster	January	18, 1999	2:30 AM						
/Medical Examiner		n, or Location of Death								
- Adminier	Collingswood Nursing & Rehabilitation Ctr. Rockvi	11e	Montgome	rv						
neral	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24	4 Hrs. 8. Date of Birth		rthplace (State or Foraign country)						
tor	190-07-4793 1 M 2 F 86 Yrs. Months Days Hours Usual Residence of Decedent	Min. (Month, Day May 19,	1912 Per	insylvania						
	10a. State 10b. County 10c. City, Town or Location			t0d. Inside City Limits						
eny injury or other traumanc event, the modula Language man by house a porter of the contract	Maryland Montgomery Rockville			1X Yes 2 □ No						
5	106. Street and Number 107. Zip Code		10g. Citizen of What C	Countra?						
a Dir	100 Watkins Pond Blvd., #303 20850		United Sta							
Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin If Yas, specify Cuban, Mexican, If Yes, Give Yaar or Dates:	in? (Specify Yas or No- Puerto Rican, etc.)	14. Raca - Arr Black, Wh Specify:							
ted	15. Decedent's Education 16a. Decedent's Usual Occupation	of wordship a	16b. Kind of Busines	s/Industry						
pe	(Specify only highest grade completed) [Give kind of work done during most of life. DO NOT use retired) [Give kind of work done during most of life. DO NOT use retired)	or working								
E	12 Medical Lab Secretar	ry	U. S. Dept	. of State						
	17. Fathar's Name (First, Middle, Last) . 18. Mother's	s Name (First, Middle,	Maidan Sumema)							
To Be	Paul Connick Eva	(Unavaila	hle)							
Ĕ	19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number			Zip Code)						
	Charlene P. Ikonomou (daughter) Same as 10		., in a committee of the							
	20a. Method of Disposition 20b. Placa of Disposition (Name of	Date	20c. Location - City of	r Town Stata						
	1 N Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)									
	4 Donation 5 Other (Specify) Gate of Heaven Cemeter	y 1-20-99	Silver Spr	ing, Maryland						
	21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Rapp Funeral Services, P. A.									
	933 Gist Avenue			Approximate						
	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cashock, or heart failure. List only one cause on each line.	ardiac or respiretory er	1051,	Interval Between Onset and Death						
n	Λ	,		J J						
ar er	Immediate Cause (Finel disease or condition a ASDINATION DNEUMO)	nid		days						
	resulting in deeth) Due to (or es e consequence of):			1						
ne				1						
Examiner	Sequentially list conditions, Due to (or as a consequenca of):									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.									
edical	that inflieted events			· 						
8	resulting in deeth) Last									
2	d									
Cia										
Ysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		_/ _	ta to the causs of death?						
by Physician/	Osteomyelitis, right heel		/ss 2 No 3□	Probably 4 Unknown						
o Be Completed by Physician/		24a. Was perlo	an autopsy 24b med?	. Were autopsy findings available prior to completion of cause of deeth?						
Eo		101	es 20 No	1 ☐ Yes 2 2 No						
	25. Was case referred to medical 26. Place of			7						
o Be	exeminer?	of Death (Check only o								
7.	1 Inpatient 2 Envolupetient 3 DOA 45 Nurs	sing Home 5 Resid	lence 6 ∐Other (Sp now injury occurred	necity)						
lon	1 Netural 5 Pending (Month, Dey Year) Injury Work?		anjuny occurred							
Certification:	2 Accident		Street and Number	Physal Paula Number						
E	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow	Street and Number or : m, State)	Hurai Houle Number,						
edicai	29a. Certifier (Check only one) 1□Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and 2□ Madical Examinar: On the basis of examination and/or investigation, in my opinion, death and manner stated.	piace, and due to the o occurred at the time, o	cause(s) and manner date and placa, and d	as stated. ue to the cause(s)						
Medicai Certification: To Be	and maintai stated.		20d Data signed /Mo	oth Day Year)						
	29b. Signature and title of certifiar 29c. License number 15 19	10 -	29d. Data signed (Mo	10 1000						
	ratucia & Tomske, 1110 0019	16	Junuary	1 10,1779						
	30. Name and address of person who completed cause of death (Item 23a) (Tyge, Print)	tona h	1 . 11 /	100 2						
	Patricia L. lomsko, MU, 11140 Rockville Pike.	348, Roc	Kville, 1	11V 20852						
State	31. Date filed (Month, Day, Yeer) 32. Registrar's Signature	10	1110							
	1021 9 0 1000 Remove 19 Room 121									

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 6 7 3

						Cert	tifica	te o	f Death		Reg. No.				
		_	1. Decedent's Name (First, Middle, I	Last)						2. Dafe of De		Wasa	3. Time of Death		
П	Physicia		MAMIE ADELE V	VARD						JANUA	RY 20,1	999	9:3UPM		
8	/Medica Examine		4a Facility Name (If not institution, g	rive street end nu	mber)				4b. City, Town, or	Location of Deat	h 4c. County	of Death			
A)	Examine	"	327 ST. MARYS	S AVENU	E - A	PARTME	NT I	M	LA PLATA	A	CHAR	LES			
H	Funeral		5. Social Security Number 8	Sex v	7. Age (In yr.	s. lest birthdey)		er 1 Yea		8. Date of Bi	rth Vacal	9. Birthp	lace (State or Foreig		
ш	Director		578-16-4569	10 M 20 F		88 Yrs.	Months	Day			1910		yland		
	D		Usuel Residence of Decedent						•						
	how	10,	10a. State 10b. County		10c. C	City, Town or Loc	ation				10d. Insid				
	Ma Ma	cto	MD Char	les		La Pl	ata				far				
	\$ 20 E	Director	10e. Street and Number				10f. Z	ip Code			10g. Citizen of	What Coun	itry?		
	th w	8	327 St. Mary	's Ave.	Apt.	M	20646 USA								
	99 E	Funeral	11. Marital Sfetus	12. Was Deci	edenf Ever in	U,S. 13. W	as Dece	edent o	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No		an Indian, etc.			
2	0 0		1 Never Married 2 Married		2 No			/es 2□ No Specify:				Specify: White			
5	Sino Sino	6	3 XWidowed 4 ☐ Divorced	Yeer or D	etes:		_ 103	2011	о ороспу.		Specin	. WILL	.Le		
5	n 72 hours neturel',	Completed	15. Decedent's (Specify only highest of			16a. Decede	ent's Us	ual Occ	upetion ne during most of wo	rkina	16b. Kind of B	usiness/Inc	dustry		
21212-0020	S		Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	life. DO NOT use retired)								
7	filed with Hygiene. ther than		8			S	ale	s C	lerk		Dept		ore		
maryland	EISE	Be	17. Fether's Neme (First, Middle, La	st)							, Meiden Sumen				
X	should be nd Mental marked c	0	George Swann						Effie	Disney	Swann				
O	0 0 0 2		19a. Informant's Name/Relationship	(Type, Print)		19b. Meiling	Addres	ss (Stre	et end Number or R	ural Route Numb	per, City or Town,	Stete, Zip	Code)		
	Health Health Sem 27 I		Robert W. Ward	1/Son		3503	Li	sa	Lane Wa	Ldorf.N	1d_2060	1			
2	200		Robert W. Ward/Son 3503 Lisa Lane Waldorf, Md 20601 20e. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removel from State 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca)												
É	nit. Pages lartment of l ortant: If its Injury or o		4 Donation 5 Dother (Specify) Cedar Hill Cemetery 1/23/99 Suitland, MD												
Dallinole,	permit. Page Department of Important: If any Injury or pnce.		21. Signature of Funeral Service Lic	ansee	1 m	00817 22.						_			
8	207 2 2		1 Just	Clas	11	TR AR	EHA.	RT-	ECHOLS 1	FUNERAI	_ HOME	P.A.			
			23a. Part1. Enter the chease, or co shock, or heart fallure. List on	mplications that of	aused the de	ath. Do not ente	r the mo	BOX	ying, such as cardia	c or respiratory	rrest, 20	646	Approximate		
	Physician		snock, or near railure. List on	ly one cause on e	ech iine.								Onset and Death		
	/Medical		Immediate Cause (Final	COL	ON CA	MCED									
	Examiner		disease or condition resulting in death)	a. COL				١.	_						
	10.00	ē			Due to	(or es a consequ	enice or	· .				ţ			
	physician and s the burial-transit	Examiner	Convention lies and distance	b	Due to	for as a consequ	ence of	1.							
2	axec	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):								t			
00/00	sicia b bur	S S	that initiated events	C	Due to	(or es a consequ	ance of	1.							
9		edical	resulting in death) Last		200 10	(or es a consequ	erice or,	,.							
YOU	nding use a	2		d											
	the deeth ce y the attendii ached for use	Physician	Part II. Other significant conditions	confeitution to d	anth hut mat see	aulting la tha un	doduina	001100	sives le Bad I	23h Dia	tobacco use or	ntribute to	the cause of death		
)	ras that the de signed by the a be detached) A	rait ii. Other eignineant conditions	contributing to di	Batti Dut Hot It	soliting in the dir	derrynig	Cause	giveri iii v att i.		Yes 2□ No	3 □ Proi			
6	5 60	Dy P									108 2010	5_1.0	SEDI) 4 DOMINIO		
3	requiras seen sign hould be									24a. Wa	s an autopsy	24b. W	ere autopsy tindings		
	been si should	ete								perf	ormed?	co	ailable prior to mpletion of cause		
)	has be 2	Completed									N. C.		death?		
o Alica Hoose	an: The la									10	Yes 21XNo	16	Yes 2□ No		
	iclan: certific rector,	D	25. Wes case referred to medical examiner?	Maneitali						ath (Check only	one)				
	hy his	0	1 Yes 2 X No			☐ ER/Outpatient	3 🗆 🖸	JUA		1	idenca 6 Oth		y)		
	After the	0	27. Menner of Death 1 □ Notural 5 □ Pending		of Injury th, Dey Year)	28b. Time of Injury		28c. in		28d. Describe	how Injury occur	red			
	Attending in deeth.	Certification:	2 Accident Investigat	bo -			М		Yes 2 No						
	after deeth Director: , d in by the		3 ☐ Suicide 6 ☐ Could not determine	286. PIECE	of Injury - Ating, etc. (Spec	home, farm, stre	et, facto	ory, offic	98	28f. Location City or To	(Street end Numi own, Stete)	oer or Rura	il Route Number,		
1	ital or after after Dir. Hed in														
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 ☐ Certifying I (Check only 2 ☐ Medical Ex	hysician: To the	best of my kr	nowledge, death	occurre	d at the	time, date and place y opinion, deeth occ	a, end due to the	cause(s) and m	anner as s	tated. the cause(s)		
	within 24 To the Fu complete		one)	and man	ner stated.										
	With To To To To To To To To To To To To To	Σ	29b. Signature end title of cartifier	o A	4		2	9c. Lice	nse number	29d. Dete signed (Month, Dey, Year)					

State Registrar 31. Date filed (Month, Dey, Year)

JAN 2 2 1999

32. Registrar's Signature

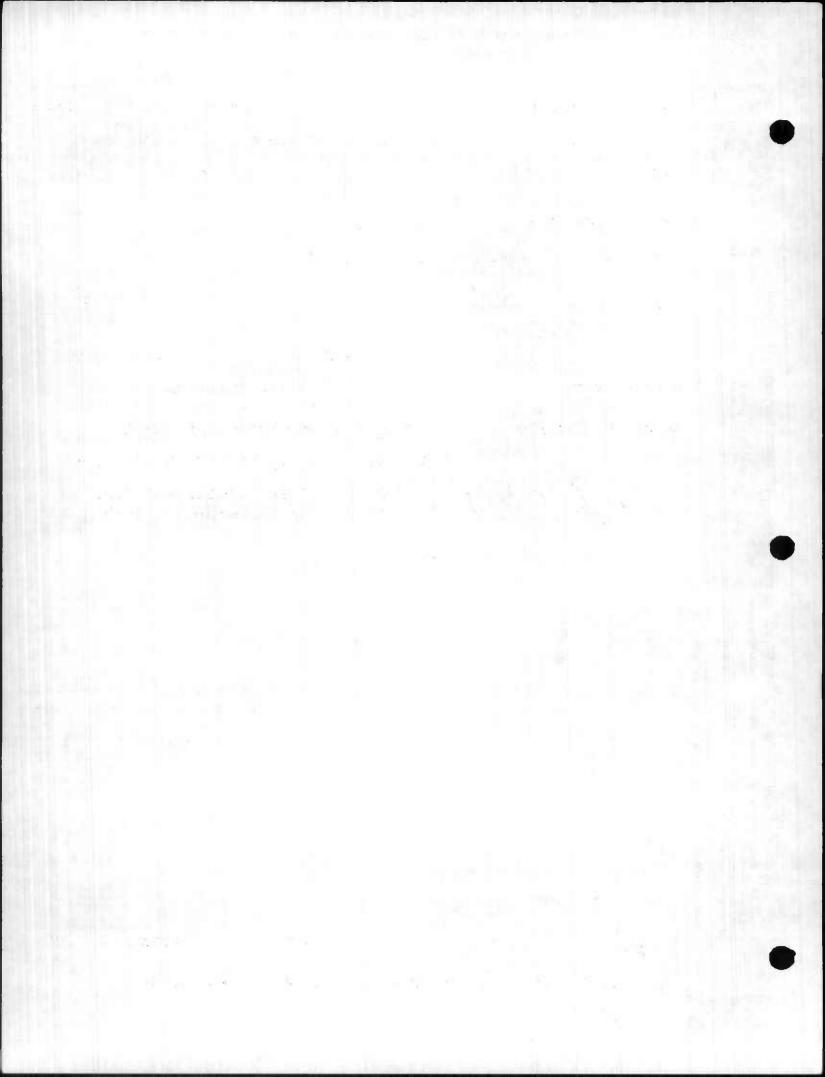
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KRISHAN MATHUR, MD., P.O. BOX 2729, LA PLATA, MD

D28352

JANUARY 21, 1999

20646]



1	-	STA	TE SIST
,	1. D	ECED	ENT'
		A	11

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR	STATE OF MARYLAND) / DEPART CERTIFIC				NTAL HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (First, Middle, Last)					2	DATE OF DEATN		3. T	IME OF DEATH
Albert David	Wolander				J	anuary 1	6 1	559	5:00AM M
222 14 2274	SEX 6. AGE (In yrs.		ONTHS DAY			Month, Day, Year)		Country)	CE (State or Foreign
9a. FACILITY NAME (If not institution, give atreet			ab CITY TOW	N OR LOCATION		ept.27,	1899	Minne	
11330B Clemsonvil				Inion E				reder	
RESIDENCE OF DECEDENT									
Maryland Frede	rick	10c. CITY,	TOWN OR LO	nion E	Bridge			200	. INSIDE CITY LIMITS?] YES 2 1 NO
100. STREET AND NUMBER 11330B Clemsonvil	le Rd.	2		10f. ZIP CODE	21791		10g. CITIZE	U.S	
11. MARITAL STATUS 12 1 Never Merried 2 Merried 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES		If yes,		Mexican, Pu	RIGIN? (Specify Yea erto Rican, atc.)	or No — 1	Black, Wh	White
15. DECEDENT'S EDUCATION (Specify only highest grade com-		DECEDENT'S U				16b. KIND OF BUS	SINESS/INDU	STRY	
Elementary/Secondary (0-12) C	ollege (1-4 or 5+)	life. Do NOT use	armer				dairy		
17. FATHER'S NAME (First, Middle, Last) Gustof Wolander				18. MOTN		First, Middle, Meiden Carlson	Sumame)		
190. INFORMANT'S NAME (Type/Print) Harold W. Nelson/	nephew					Number, City or Town			21791
20s. METHOD OF DISPOSITION	20b PL A	CEANDDATEOR			- Ra.		CATION - CI		
1 X Buriel 2 Cremetion 3 Removal 4 Donalion 8 Other (Specify)	from State connectory,	rgreen	Mem. (ardens	s 1	/19 Fin	ksbur	g. MD	
21. SIGNATURE OF FUNERAL SERVICE LICENS	EE O / La)	22. NAME	AND ADDRESS	S OF FACILIT	Hartzler	Fune	ral H	omo
atharine (, Harse		6 E.	Broad	lwav	Union Br	idge.	MD 2	1791
23. PART I. Enter the diseeses, or com shock, or heert fellure. List	plications that caused the	death. Do no							Approximate
IMMEDIATE CAUSE (Final									Interval Between Onset and Death
diseese or condition resulting in death) s	con ges	HUR		TEAN	1	(-B1	UR	E	141
_	DUE TO OF AS A CON	SECUENCE OF):	an		1, 1	0010		i	20445
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CON				1 /2	1000		+	7,5
cause. Enter UNDERLYING CAUSE (Disease or injury									
that initiated events resulting in death) LAST	DUE TO (OR AS A CON	ISEOUENCE OF):	*					l	
d									
PART II. Other algnificant conditions of	ontributing to deeth but no	ot resulting in	the underly	ing ceuse gi	ven in Part	1. 24s. WAS AN PERFOR	MED3	CON	NE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION OF CAUSE
DID TOBACCO USE CO	ONTRIBUTE TO CA	AUSE OF	DEATH	YES 🖂	NO	*			PEATN?
25. WAS CASE REFERRED TO MEDICAL			26.	PLACE OF DE	ATN (Check o	nly one)			
	OSPITAL: Inpatient 2 ER/Oulpatient		OTHER: Nursing H	ome 5 Pes	idence 8 🗆	Other (Specify)			
27. MANNER OF DEATH Natural 5 Pending Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY	NJURY AT WORK? YES 2		I. DEŞCRIBE NOW II	NJURY OCCU	RED	
3 Suicide 6 Could not be determined	26s. PLACE OF INJURY — Albuilding, atc. (Specify)	t home, farm, str	reet, factory, o	fice	281	. LOCATION (Street a City or Town, State)	and Number or	Rurel Route	Number,
29a. CERTIFIER CERTIFYING PHYSICIAN	Y: To the best of my knowledge	, danth occurred	at the time of	If and place	and due to th	o causals) and re-	mer se state d		
	n the beals of exemination and								manner as stated.
296. SIGNATURE AND TITLE OF CERTIFIER	1 10			_	ISE NUMBER			SIGNED (Myr	
Son M	July	1 M	0	17:	20	30	1	116	194
38. NAME AND ADDRESS OF PERSON WHO CO	MIDI ETED PAUSE OF DEATH	ITEM OT CENT	Online)	-			_		

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

JOIAN

31. DATE FILED (Month, Day, Year)

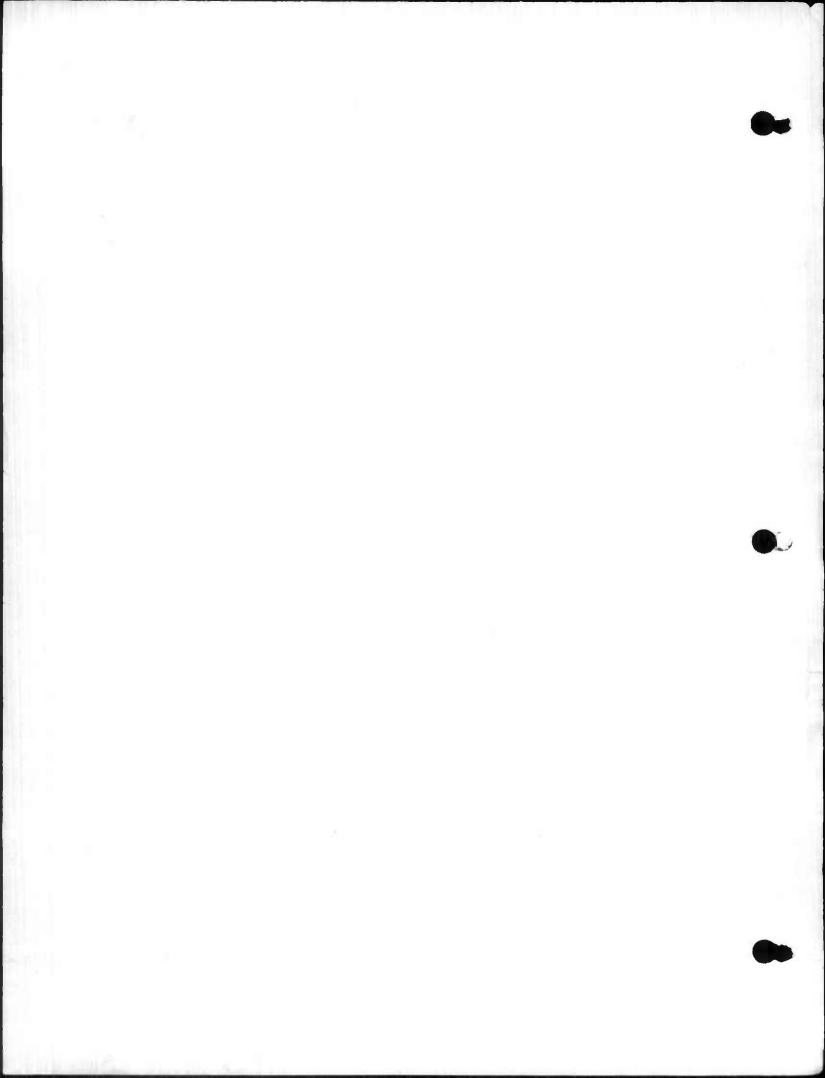
JAN 1 9 1999

UE #104

BALTIMORE, MARYLAND 21215-0020

DHMH-18 Rev 1/89

St. , UMON BNOGE



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month **Physician** Elton Lee Wright, Sr. 99 14 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll If Under 24 Hrs. Birthplace (Stata or Foreign Country) If Under 1 Year 8. Data of Birth (Month, Day, Year) Mar. 24, 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday). **Funeral** Days Months Hours 1 X M 2 □ F Maryland 217-10-9812 Director Usuel Rasidance of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural, or items 23s or 28s-f show the Wedgel Examiner must be notified at 1 ☐ Yas 2 No Carrol1 New Windsor Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2333 Marston Rd. 21776 Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Black, White, etc. 72 hours after 1 X Yas 2 No
If Yas, Give
Yaar or Dates: 1944-46 1 Nevar Married 2 Married White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if fem 27 is marked other than 'na any injury or other traumatic evene. Army Corps of Elementary/Secondary (0-12) College (1-4or 5+) Engineers inspector 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Allen Thurman Wright Margie Hanna Waltz t9b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) Joan L. Lindsay/ daughter 2591 Marston Rd. New Windsor, MD 21776 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Crametion 3 ☑ Removal from Stata St. Stephen's Cemetery 1/18/99 Amherst, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Hartzler Funeral Home 21. Signature of Funcial Sarvice Licenses 310 Church St., New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me. Approximete Interval Between Onset end Death **Physician** /Medical Immediata Cause (Final disaasa or condition resulting in death) RESPIRATORY INSUFFICIENC MINUTE Examiner Due to (or as e consequence of): Examiner physician and s the burial-transit HRONIC OBSTRUCTIVE DISERSE the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initieled evants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): ed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part If. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. NZ Yes 2 No 3 Probably 4 Unknown CONFECTIVE HEART FAILURE Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed ASCITES 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar?
1 ☐ Yas 2 ☑ No Be 26. Place of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of After 5 Panding investigation Natural a Funeral Director: A bletchy filled in by the fi death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital o within 24 hours at To the Funeral D 15/ Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian completely (Check only one) 29b. Signatura end titla of certifian 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and addrass of purson who completed ceuse of death (Item 23a) (Type, Print) DO1663

Registrar

State

VINCENT

31. Data filed (Month, Day, Year)

JAN 1 9 1999

DHMH 16 Rev 6/95

FIOCCO

-JR

32. Registrar's Signatura

9060 WASHINGTON

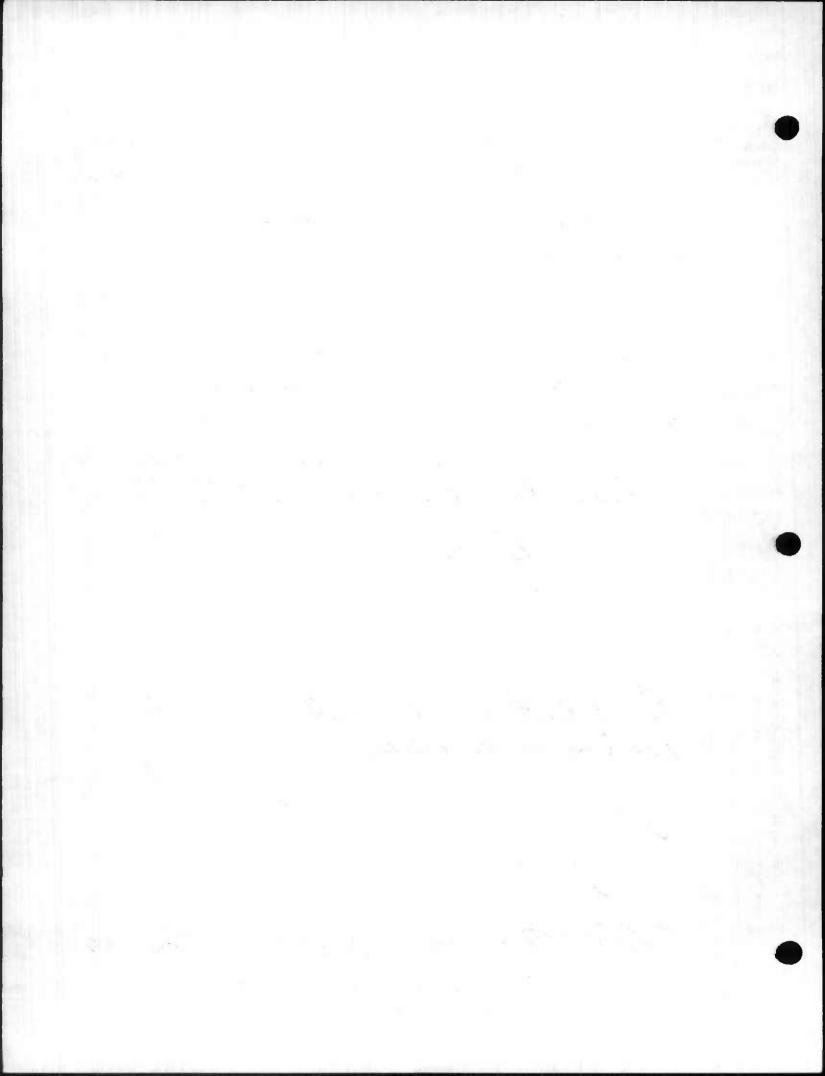
WESTMINSTER MD 21157



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieneg 9 0 2 6 7 6

						Ce	rtificate of	Death	,	Reg. No.	02010
П	Dis 1st 1st		1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	ath	3. Time of Deeth
	Physici /Medi		Oda	Ament W	latt					15, 1999	
	Examir		4e. Fecility Neme (If not institution, give	e street end number)				4b. City, Town, or		4c. County of I	Death
			Carroll Lutheran	Village				Westmin		Car	roll
	Funeral Director		277 20 0234	ex 7. Age	(In yrs. lest bir	thday) Yrs.	If Under 1 Yea Months Days		8. Date of Bird (Month, Da Sep 23	y, Year) 9. 1, 1902	Birthplace (State or Foreign Country) Maryland
	A L		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	ocation			7.75	10d. Inside City Limits
	e Maryli la-f sho	ctor	Maryland Carro	11				Westmin	ster		1 ☐ Yes 2√ No
	th with the	Funeral Director	10e. Street and Number 201 St. Mark's Wa	У			10f. Zip Code	21157		10g. Citizen of Wha	
5-0020	s 1 and 2 should be filed within 72 hours after death with the Manyland Haalth and Mental Hygiena. Haalth and Mental Hygiena. If the T27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Heulical Example must be notified at	by	11. Maritai Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 1 1 If Yes, Give Year or Dates:			Wes Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☑ No	Hispenic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Black, V	American Indian, White, etc. White
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a.	Dece (Give	dent's Usual Occu	pation a during most of wor ed)	rking	16b. Kind of Busin	ess/Industry
2121	within ena. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.		•	9	0 **	
22	filed v Hygie offher t		17. Father's Name (First, Middle, Last)				Housev		no (Eiret Middle	Own H	iome
an	d be f	Be c	George Wesley Am						Matilda		
Maryland	12 should be fi h and Mental H is marked off raumatic aver	To	19a. Informant's Name/Relationship (7		196	. Mailir	na Address (Stree			er, City or Town, Ste	ite. Zip Code)
	and 2 saith a n 27 is		Edward A. Watt,							er, MD 21	
Baltimore,	of Had		20a. Method of Disposition 1√2 Buriel 2 ☐ Cremation 3 ☐	Damoval from State	20b. Placa o cemete.	f Dispo	osition (Neme of metory or other pla	ece)	Date	20c. Location - City	y or Town, Stete
tim	E Pages tment of I tant: If ite		4 Donation 5 Other (Specify)	Lake V	/iev	w Memoria	al Park	1/19	Sykesvi	lle, MD
Bal	permit. Pages 1 and 2. Department of Haalth as Important: If item 27 is any injury or other tracence.		21. Signeture of Fureral Service Licen	$\omega \epsilon$	len	e 22	2. Name and Addr			neral Homstead, MD	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do	not ent	ter the mode of dy	ing, such as cardlad	or respiratory a	rrest,	Approximate Interval Between
	Physician /Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)	45	Due to (or as e						Onset and Deeth
٠	bd it	ine		Jenil	- 6						i
-	tificata be axecuted ig physician and as the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consec	quenca of):					
68760,	ysician ysician		that initiated events	c	Oue to (or as a	солѕео	uence of):				
		Physician/Medical	resulting in death) Last	d	,		,				
Box	attend for us	ian		U							
o.	the de	ysic	Part II. Other significant conditions of	ontributing to death bu	t not resulting li	n the u	nderlying cause g	iven In Part I.			buta to the cause of death?
۵.	s that i	by Ph	Chemil de	ath z	ine	He	degue	li	10	Yes 2 PNo 3	☐ Probably 4 ☐ Unknown
Records,	v requires that the death certificate be axecuted been signed by the attending physician and should be detached for use as the bunat-transit	Completed	fool +	wefer	- ins	Som	te			an autopsy 2 prmed?	4b. Were autopsy findings availeble prior to completion of cause
Rec	S S S	duic	0						10	Yes 2 No	of death?
Vital	ician: Th cartificate rector, pa	0	25. Was case referred to medical					06 Place of Day	ath (Check only		1 Yes 2 No
>	Physician: r this cartific rral director,	ToB	evaminer?	Hospital:	nt 2∏ FB/Ou	tnatier	nt 3 DOA O	ther		dence 6 ☐Other (Speciful
n of	ta and		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Dey		rime or				how injury occurred	Ороспу
sio	Attending or death.	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 No			
Division	after of Dirac	Certification:	4 Homicide determined	28e. Placa of Inju building, etc	ry - At home, fa . <i>(Specify)</i>	rm, str	reet, factory, office		28f. Location (City or To	Street end Number (vn, Stete)	or Rural Route Number,
П	To the Hospital or Attendiwithin 24 hours after death. To the Funeral Diractor: A completely filled in by the fu		29a. Certifier 1 Certifying Phy	valcian: To the best o	f my knowledge	, death	h occurred at the t	ime, date and place	, and due to the	ceuse(s) and manne	er as stated.
	the Horin 24 the Fu	ledical	one)	Iner: On the basis of and menner sta	examination an led.	d/or In	vestigation, in my	opinion, death occu	rred at the time,	date and place, and	due to the ceuse(s)
	To To To Com	Σ	29b. Signature and title of pertition	7-	110		29c. Licer	se number		29d. Date signed (A	Month, Dey, Year)
			100	//	NU		100	4618		1/W/8	194
			30. Name and address of person who					tox MD	21157		
	Sta	to	Dean H. Griffin, 31. Date filed (Month, Dey, Year)		r's Signature	u,	WESUILINS	ster, MD	7113/		
	Registr		JAN 2 0 199		wa	G.	Sport	h			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) **Physician** ROBERT Januar, 15, 1999 ation of Death 4c. County of Death JOSEPH WEST 1200 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva straat and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 15 M 2□ F 212-56-2021 49 January 5,1950 Pennsylvania Usual Rasidence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Ohio Montgomery Centerville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 526 Stonington Circle 45458 USA Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11 Marital Status 1 Yas 2 XNo If Yas, Give Yaar or Datas: 1 ☐ Nevar Married 2 Married 1 Yas 2 XNo Specify White P 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Religion Pastor 12 10 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Be James P. West Alice Lundberg 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Peggy L. West/Wife 526 STonington Circle, Centerville, OH 45458 20b. Placa of Disposition (Nama of cemetary, crematory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 1/16/99 Salisbury, MD 4 ☐ Donation 5 ☐ Othar (Spacify) Salisbury Crematory 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest,

April Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest,

April Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest,

April Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest,

April Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximate Intarval Between Onset and Death Immediate Causa (Final diseasa or condition resulting in death) Dua to (or as a consequence of): Oral Vagandar Accident Occipital 1/22 Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 42 Unknown 1 Yss 2 No by 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 PNo 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatlent 3 DOA 28d. Describe how injury occurred 27. Mannar of Death 28a. Data of Injury (Month, Day Yaar) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending pontaneous 99 1 Yas 2 No 12/ invastigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 4 Homicida HOME - Hotel. 12 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death.

Funerel Director: A To the Hosp within 24 ho To the Fune completely fi

Funeral

Director

r 28a-f show

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a

permit. Pages 1 and 2 should be filed within 72 hours effer death a Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s any injury or other traumatic event, the Medical Example master.

Physician /Medical

Examiner

attending physicien and for use es the bunal-transit

signed by the a

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director.

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filled In

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After

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Baltimore, Maryland 21215-0020

with the Maryland

State Registrar

31. Date filed (Month, Day, Year) JAN 1 9 1999

29b. Signatura and titla of certifier

jom

MD. 32. Registrar's Signature

day of daath (Itam 23a) (Type, Print)

29c. License number

29d. Daja signed (Month, Day, Year)

JAN 1 B THE STATE OF THE STATE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 02678 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Mary Н. Zimmerman January 13, 1999 8:15 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3352 Chiswick Court, #3H Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 18, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF Yrs 503-16-5065 75 Iowa Director Usual Residence of Decedent the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yas 2 ☐ No Directo 28a-f Maryland Montgomery Silver Spring 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 238 3352 Chiswick Court, #3H 20906 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Barra 14. Race - Amarican Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 8 Specify: White 1 ☐ Yes 2 No Specify: p 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cedar Lane Unitarian Elementary/Secondary (0-12) College (1-4or 5+) Universalist Church Church Administrator 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Pages 1 and 2 should be fill ment of Health and Mental H and: If Item 27 is marked off lury or other traumatic even 88 Wilber Hamilton Hill Frances Paulsen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Z. Darne (daughter) 6312 North 36th Street, Arlington, Virginia 20b. Place of Disposition (Name of 20a. Mathod of Disposition Date 20c. Location · City or Town, State ery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from Stata permit. Page Department of Important: If any Injury or 01 - 14 - 994 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 21. Signature of Funeral Service Lic 22. Nama and Address of Facility
Rapp Funeral Services, P.A. M00956 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) BRAIN /Medical METASTASIS 6 MONTHS Examiner Due to (or es e consequence of) Examiner LUNG CANCER 6 MONTHS use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): been signed by the atter should be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24e. Wes an autopsy parformed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 1 Yes 2 No 1 Yes 2 No of Vital or Attanding Physician: after death.
Director: After this certifica director. 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 20 No Certification: To funeral 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending investigation 1 Natural To the Hospital or Attandit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide † Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 042452 MARYLAND Chile Rega M.D Thrusky 14, 1998 12 Knel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLNEY, MD 20832 PHILIP DRIVE, #327, DR. CHITRA 18111, PRINCE RAJA GOPAL, 4.3.

DHMH 16 Rev 6/95

State

Registrar

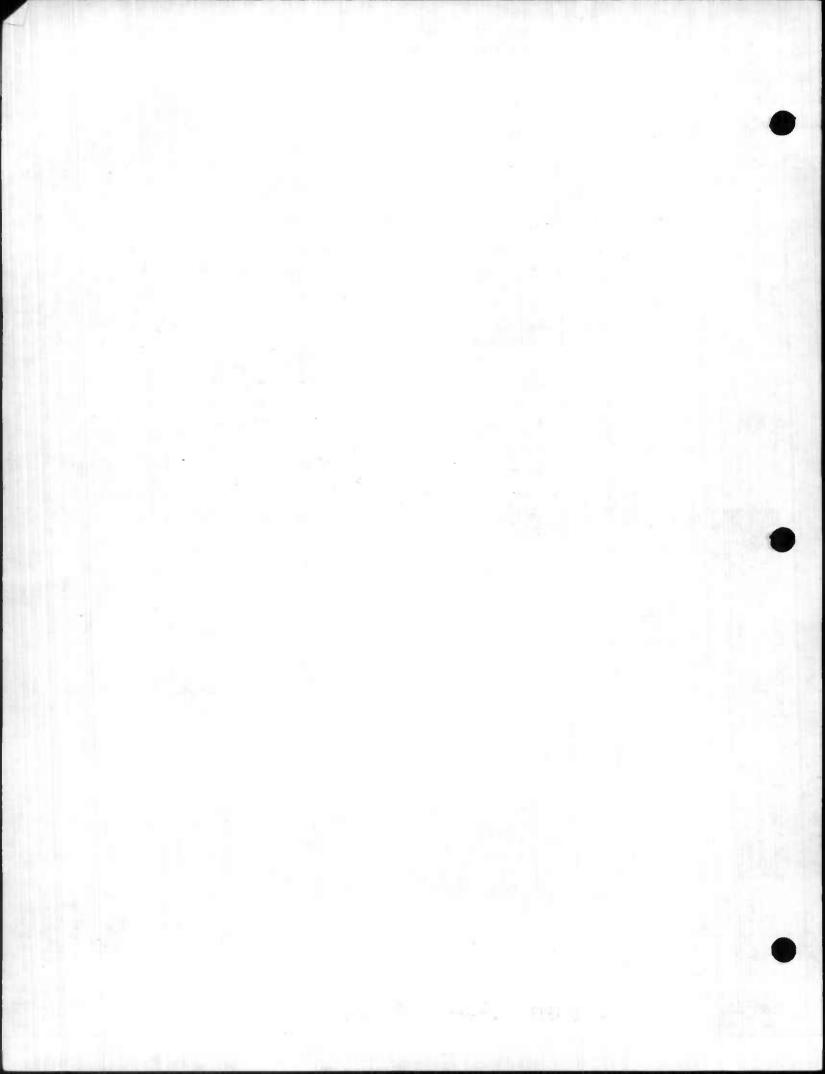
31. Date filed (Month, Day, Year)

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32. Registrar's Signature

1999



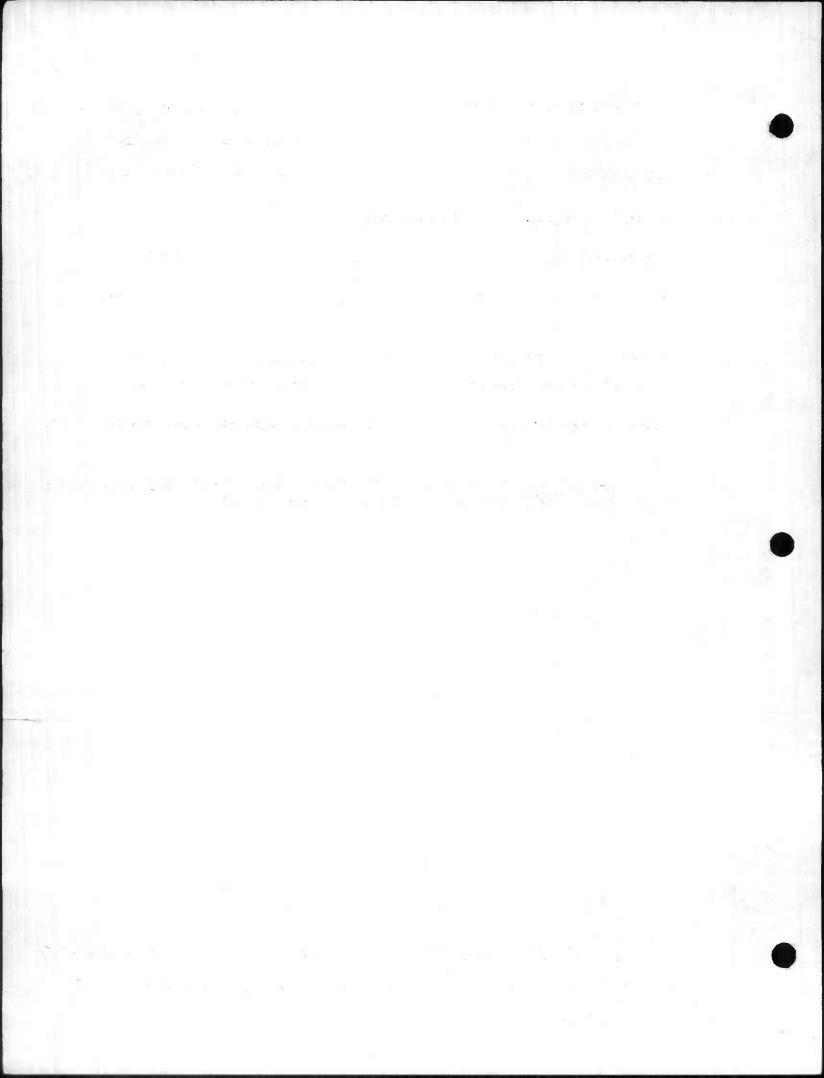
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth **Physician** Bessie Virginia Albright 23, 1999 1:45 AM January /Medical 4a. Fecility Nema (If not institution, give street and number) 4b, City, Town, or Location of Deeth 4c. County of Death **Examiner** Gaithersburg Wilson Health Care Center Montgomery If Undar 1 Yaar If Under 24 Hrs. Months Days Hours Min. 9. Birthplece (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Dey, Yea. **Funeral** Days 1□ M 2□ F May 4, 1913 85 Yrs. **Director** 579-48-7017 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or leams 23s or 28s-f.sho event, the Medical Examiner must be notified at Maryland Montgomery Gaithersburg 1 Tyes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 U.S.A. 401 Russell Avenue Funeral 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - Amarican Indian, Bleck, White, atc. Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, apecify Cuban, Maxican, Puarto Rican, atc.) Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Detes: "natural", or Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72.h Department of Health and Mental Hygiene. Important: If New 27 is marked other the any injury or other trausment other the other than 100 and 18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Induatry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown Secretary unknown 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middla, Meldan Surnama) Moses Lorenza Dow Albright Sarah Frances Campbell 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Wilma Albright/sister 401 Russell Avenue, Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☑ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee Wade, State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, or heart feilure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediata Causa (Finel week disaese or condition resulting in deeth) Examiner Examiner mos nerpes The law requires that the death certificate be executed ettending physician and for use es the burial-tran Sequentielly list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or es e consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wera autopsy findings available prior to Completed 24e. Was an autopsy performed? Deed completion of cause of death? s certificate hes t director, page 2 s 21 NO 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: Annual Survivation of the August 19 Aug 10 1 Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA To the Hospital or Attending Physi within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral dir this 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1-Neturel 5 Pending investigation 1 Yea 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piaca, and due to the cause(s) and manner es atated.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner ateted. 29a. Certifier edicai (Check only one) 29b. Signature and title of certifier 29c. Licansa numbar 29d. Date signed (Month, Day, Year) 30. Name and andress of person who complated cause of deeth (item 23e) (Type, Print) R. RUSSELL mewich GAITHERMUL Me 911 31. Dete Med (Month, Dey, Year)
FEB 0 3 1999

32. Registrer's Signeture

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 02680 State of Maryland / Department of Health and Mental Hygiene 9 Items 26 Per PHY FilmG768 2-3-99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:00AM Istelle Brewer 30 lice an /Medical 4e Fecility Name (If not institution, give street and number)
3391 Dulany Street 4c. County of Deeth
Baltimore City 4b. City, Town, or Location of Deeth Examiner Baltimore 7. Age (In yrs Jast birthday) If Under 1 Year | Months Days Birthplece (State or Foreign Country)
 Virginia Social Security Number 227-20-5627 **Funeral** 1 □ M 2 F Days Hours Yrs. **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Howard Maryland Ellicott City 1 XYes 2 □ No Director 10g. Citizen of What Country? U.S.A. 10e. Street and Number 13070 Triadelphia Road 10f. Zip Code 21042 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo if Yes, Give / Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritai Stetus Black, White, etc. 1 Never Married 2 Married White "natural", or 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Textile worker Completed 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Heelth and Mental Hygiena. Important: if item 27 is marked other than "nat any injury or other traumatic event, the Moriea and 100. 15. Decedent's Education (Specify only highest grade completed) Textile Elementery/Secondery (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)
William M. Sealock 18. Mother's Name (First, Middle, Maiden Surname)
Elsie Wood Crickenberger P_ 19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13070 Triadelphia Road Ellicott City, Maryland 21042 19a. tnforment's Neme/Relationship (Type, Print) Mr. William I. Brewer Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Good Shepherd Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Remove from State
4 Donation 5 Other (Specify) 02/01/99 Ellicott City, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 1200057 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, // shock, or heart feilure. List only one cause on each line. Approximate tntervel Between Onset and Death **Physician** Breast Cancer /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner requires that the death certificate be axecuted bunel-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last pue Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attanding physician Physician/Medical the Due to (or as e consequence of): 88 use signed by the a d be datached f Part tt. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 27 No 3 Probably 4 Unknown bowel syndrome Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? certificata has 1 ☐ Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was cese referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Jother (Specify) 2 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Neturel 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours efter deeth. To the Funeral Director: At investigation 2 ☐ Accident 6 Could not be determined 26e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)

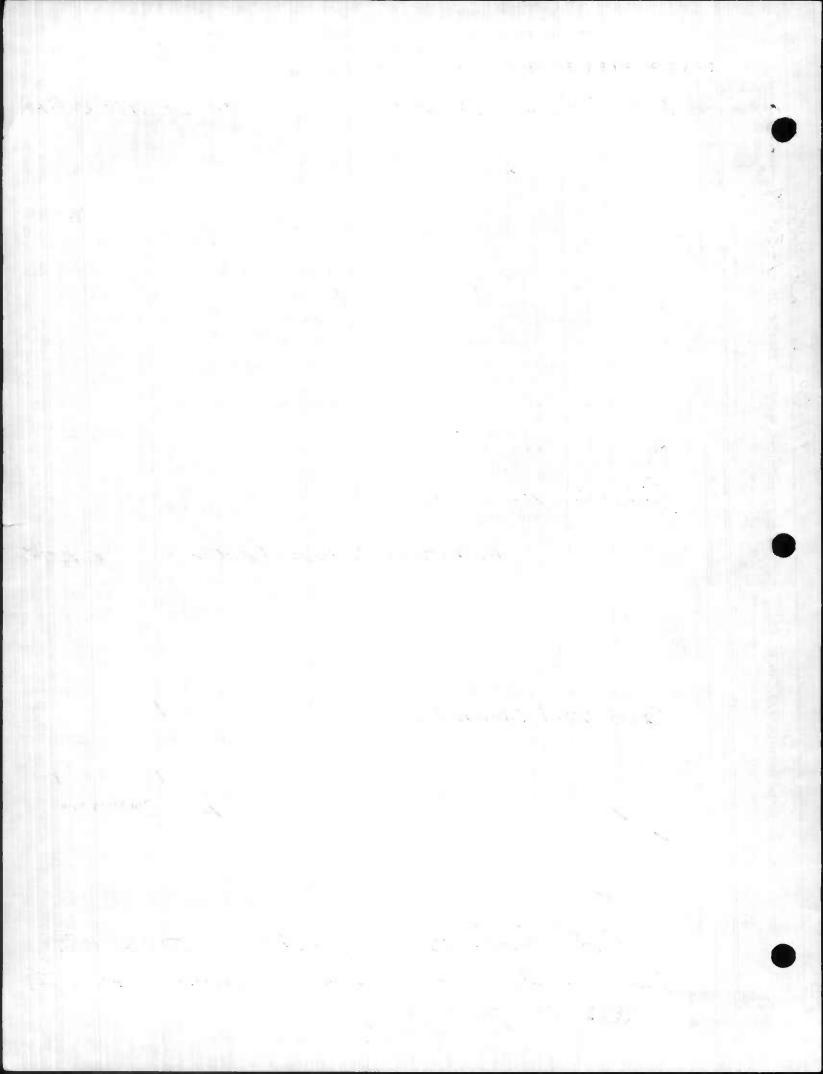
JAN 30 1999 29c. License number 018587 ess of person who completed ceuse of death (Item 23a) (Type, Print) fue Bathmore MD 21229 GOVM 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

FEB 3

1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month 12.25 PM EGINA BIGGS JANUARY 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL CENTER BALTIMORE N/A If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 F Months 220-18-4599 24, 1926 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Md. Anne Arundel Linthicum 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 763 Hawthorne Road 21090 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ※☐ No If Yes, Give Yaar or Datas; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 □ Naver Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8th 0 Homemaker Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Germanus Hock Helena Kleinhenn 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark B. Biggs (Son 544 Cleveland Road Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Cem, 2/1/99 Baltimore, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funaral Service Licensee 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only one cause on each line. Approximete Interval Between Onset and Death tmmediate Ceuse (Final disease or condition resulting in death) HEPATIC ENCEPHALOPATHY DAXS ALCOHOLIC CIRPHOSIS WITH PORTAL HYPERTENSION Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last CANCER WITH MULTIPLE METASTASIS ARYNGEAL Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of degth? 1 Yaa 2 No 3 Probably 4 Punknown ANEMIA 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy 2 1 No 1 ☐ Yes 2 1 No 1 ☐ Yes 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Ptaca of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed physician s the burial Box 68760, Division of Vital Records, P.O. or Attending Physician: After this

Examine Physician/Medical Certification: To Be Completed by Hospital or Attending 24 hours after death.
 Funeral Director: After

Physician

/Medical

Examiner

Director

Funeral

Be

Funeral

Director

28a-f

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Pages 1 and 2 should be filled nent of Health and Mental Hygi art: If them 27 is marked other

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Physician /Medical

Examiner

timore, Maryland 21215-0020

1 Yes 2 No 27. Manney of Death 1 ☑Neturat 2 Accident 3 Suicide 4 ☐ HomicIde

29e. Certifier

(Check only one)

6 Could not be determined

281. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and manner stated. 29b. Signatura and fitterof certifian

RESIDENT IN INTERNAL

P /3 130

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. BALASUBRAMANIAN JAYALAKSHMI 3001

S. HANOVER ST. BALTIMORE MD 21225

State Registrar

filled in by

completely

Within 2 945

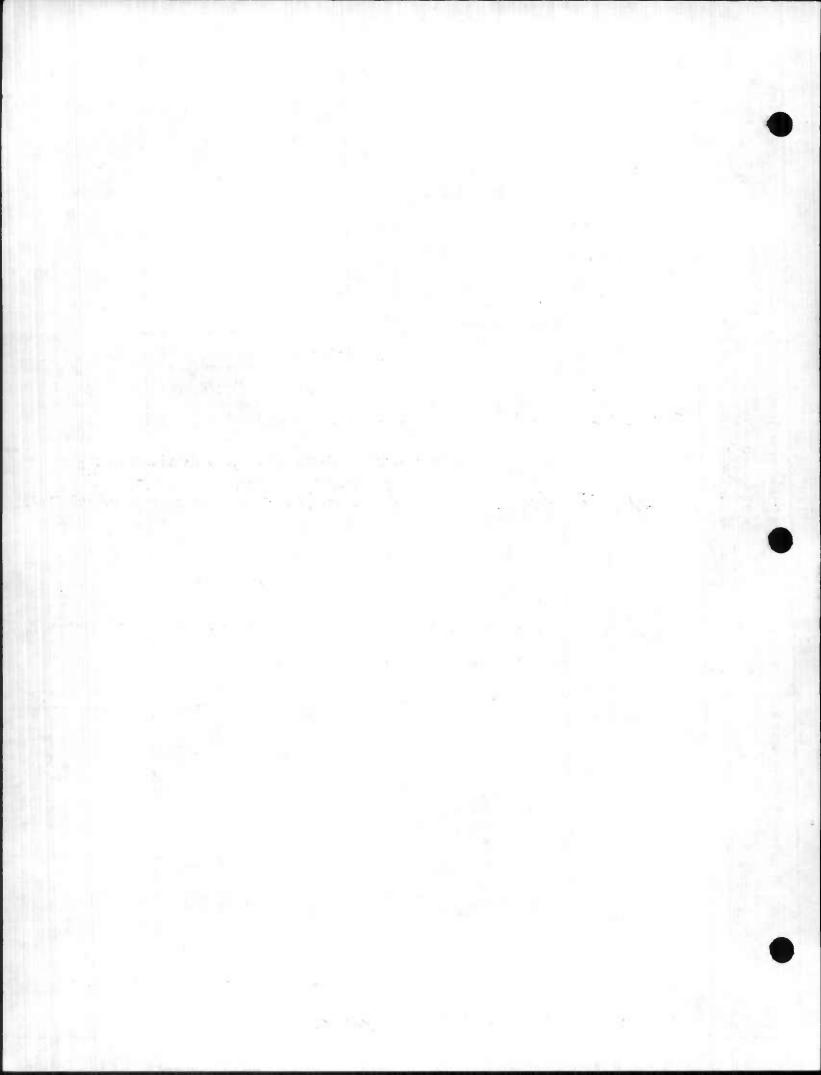
31. Date filed (Month, Dey, Year)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, dete and place, and due to the ceuse(s) and manner as stated.

29c. License number

DHMH 16 Ray 6/95



Please Type or Print in Black indelible lnk. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 9 02682

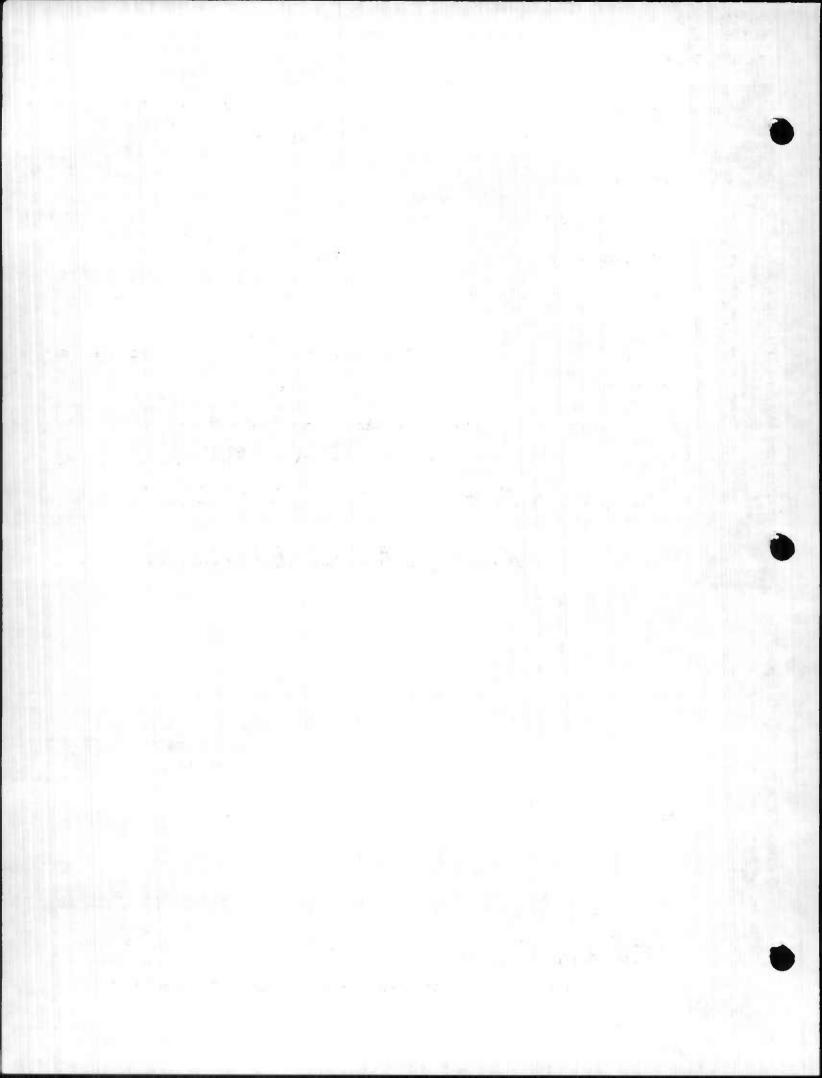
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State Registrar

Theodore King M.D. 31. Dete filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Item 20a,22 Pe A.B. Film G768 2-3-99 rja Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 8:55Pm YNE BOWL /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Partimores Mac Baltimore City Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1□ M 200€ 215-16-9574 Yrs. 6/27/14 **Director** Usual Residence of Decedent Baltomore, Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours efter death with the Marylan in end Mantle Hygiene.
7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Majical Experience mail be notified at 740. Poplar Yes 2 No Baltimore City Director ma. este Ht ave. 101. Zip Code 10g. Citizen of What Country? 10e. Street and Number 429 Seave Street 21267 U.S.A. 740 Funeral 14. Race - American Indian, 11. Marital Status . Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2√ No Specify: Specify: Black λq 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) unknown unknown unknown unknown 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) unknown. addie Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health end Important: If Itam 27 is n eny injury or other traun Dowles 20b. Place of Disposition (Name of cemetery, crematory or other place) palto. Ned Beverly , 21207 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 1 Burlal 2 Cremation 3 Condition 4 Donation 1 Donation 1 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore St 21. Signature of Fureral Service Ligensee Ronald S. Wade Director 23a. Pakt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, thick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Cell Long Caronon disease or condition resulting in deeth) year Examiner Examiner ician and bunal-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): attending physician for use as the buna Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen: has certificate 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Affer Neturel Injury 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide

certificete be Division of Vital Attending Physician: death. ne Hospital or Attendi n 24 hours effer death ne Funeral Director: A

the Maryland

Baltimore, Maryland 21215-0020

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

21202

29a. Certifier (Check only one) Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

4 Homicide

D40854

29c. License number

29d. Date signed (Month, Day, Year) 19

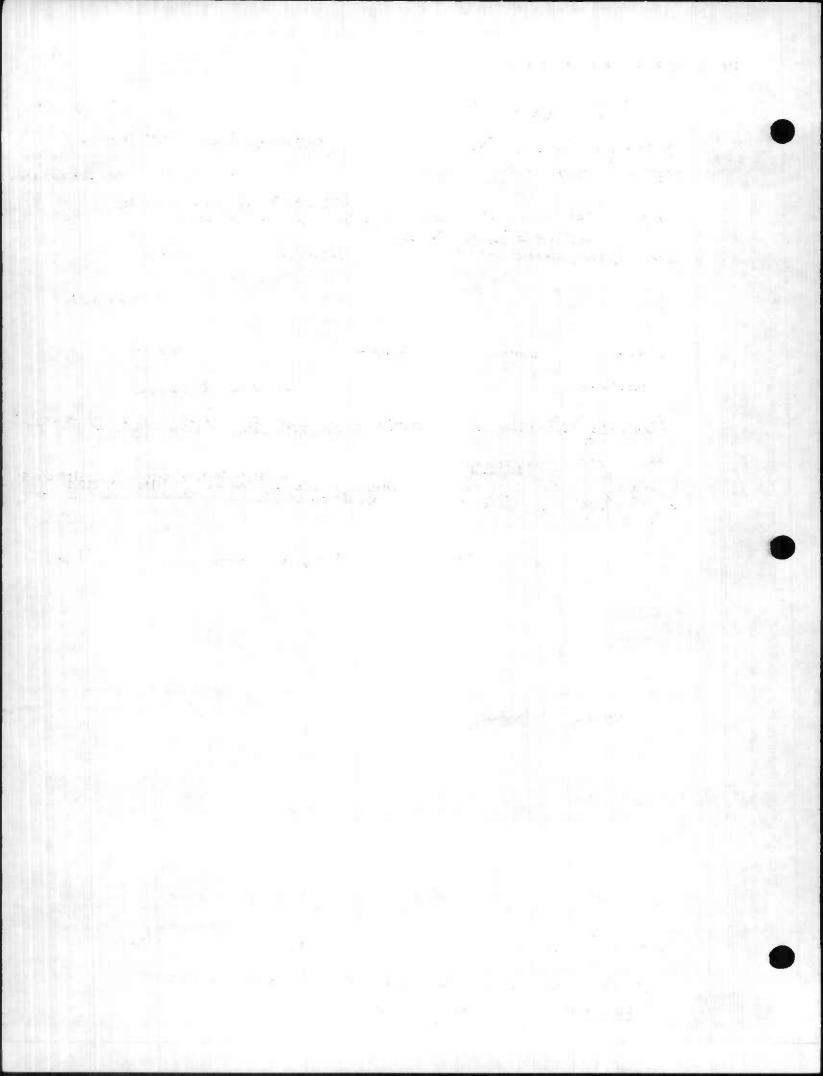
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 301 St Paul Buldrer

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 0 3 1999 32. Registrar's Signature

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dooker 28 Vimile 1999 10 A Jan 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number, 4c. County of Deeth Baltimore n/a NWSING (ST. Age (In yrs. last birthday) Long (5. Social Security Tumber If Under 1 Year Green If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 10 M 20F 95 218-22-2883 July 14, 1903 Va. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits n/a Baltimore Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4500 Kenilworth Avenue 21212 USA 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1□ Yes 2□ No Specify: Specify:Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Hoffberger Pastry Cook 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) General Womack Frances Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) daughter 4500 Kenilworth Avenue Baltimore, Md. 21212 Frances Booker McDaniels 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 € urial 2 □ Cremation 3 □ Removal from State Feb. 2 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signeture of Funeral Service Licansee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) chromic Due to (or as a consequence of) malme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Md.

Director

Funeral

þ

Completed

Be

Funeral

Director

"natural", or items 23s or adical Examiner rount be r

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, it a Medical Examiner count. DOCS.

Baltimore, Maryland 21215-0020

with the Marylend r 28a-f ahow notified at

> Examiner Physician/Medical þ Completed

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Certification: To

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physicien and s the bunal-transit attanding pt for use as t ed by the a signed b should b certificata has b al or Attending Physician: T s aftar death. Il Director: After this certificat ed in by the funeral director, p 24 hours after Funeral Dire letely filled in b

The law requires that the death certificate be axecuted

P.O. Box 68760.

Division of Vital Records.

Hospital

To the Vithin 2

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes ZONo

1 Yes 2010

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

	examiner?		
27	Mannar of	Oosth	

5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

14 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

daya

29c. License number 31464 29d. Dete signed (Month, Day, Year)

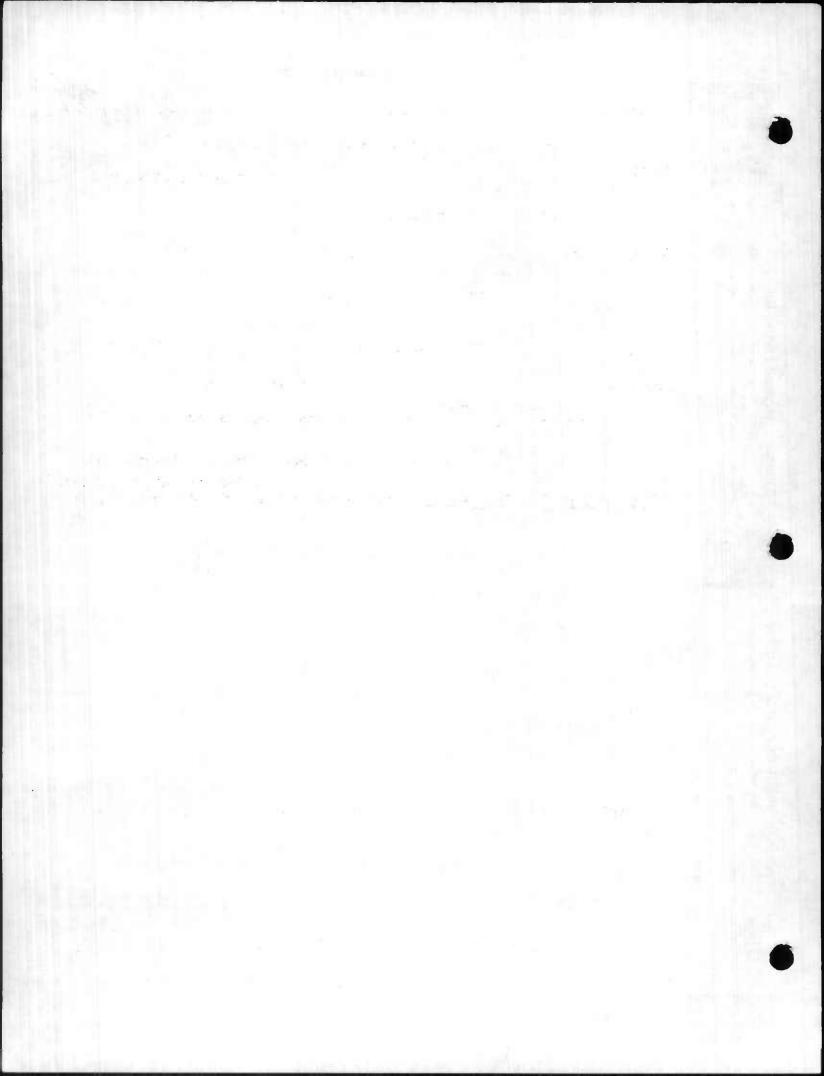
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Entow St Inte 308 (tASHm) 821 N.

State Registrar 31. Date filed (Month, Day, Year) 3 1999 FEB



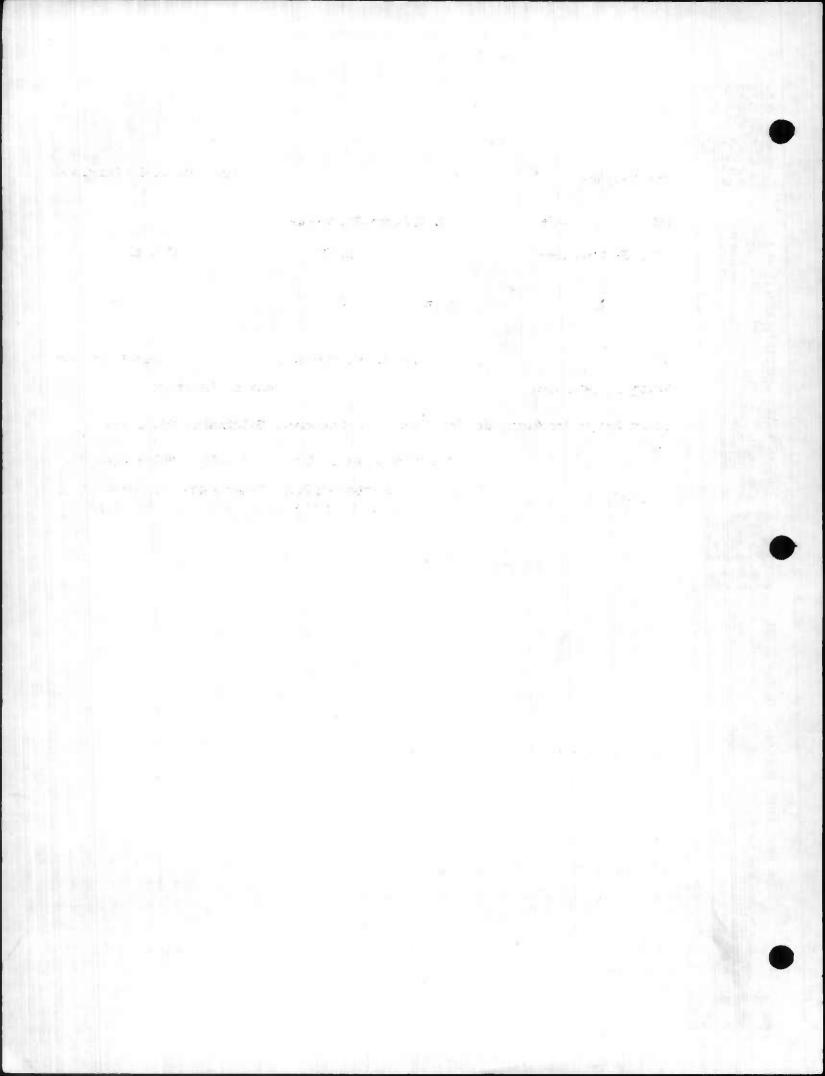




Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 0 2 6 8 5 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth 725 P **Physician** BRUCE L. BRADBURN 1999 January 31 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** BALTIMORE BAYVIEW HESPITAL HOPKINS JOHNS | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | Oct. 14, 1953 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** 1**X**M 2□ F Maryland 45 Yrs Director 214-54-2785 uel Residence of Deceder the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow r than "natural", or items 23s or 28s-f show 1₽Yes 2□No Directo Md. N/A Baltimore-St.Helena 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21222 U.S.A. 6555 Parnell Ave. filed within 72 hours after death v Hygiene. other than "natural", or items 23. Funerai 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11 Marital Status 1 XYes 2 No
If Yes, Give
Yeer or Deles: 72-74 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cottege (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: if item 27 is marked other that any injury or other traumatic event, the once. Tow Motor Operator Steel Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Percy F. Bradburn Emma L. Cummings 19a, Informent's Name/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6555 Parnell Ave., Baltimore, Md. 21222 Bruce Lloyd Bradburn, Jr./Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlei 2 Cremetion 3 Removel from State
4 Donation 5 Other (Specify) Gardens of Faith Cemt. 2-4-99 Baltimore, Md. 21. Signeture of Funerei Service Licenses 22. Name end Address of Fecility achael L. Tesser Bradley-Ashton-Matthews Funeral Home, Inc. 23e. Pent1. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart failure. List only one ceuse on each line. 2134 Willow Spring Rd., Balto., Md. 21222 enter the mode of dying, such as cardiac or respiratory errest. Intervet Between Onsel end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Subarrebanord hamonhage 42 WKO Examiner Due to (or es e consequence of). Examiner physician and the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initioted events resulting in deeth) Lest Due to (or es a consequence of): Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23h. Did tobacco usa contribute to the cause of death? the s signed by 1 Yes 2 No 3 Probably 4 Unknown systemic embol 0 Records, þ 24b. Were eutopsy findings eveltable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medicet exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA this After this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Naturel n 24 hours after death.

Ne Funeral Director: Al 1 Tyes 2 No efter death. 2 ☐ Accident 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Sulcide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 D Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) pletely To the I within 2 To the I complet 29b. Signature end little of certilier 29c. License number 29d. Dale signed (Month, Day, Year) Una 8002 4802 MO 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Baltemore, MD Browner Johns Hopkins Hene S. 31. Date filed (Month, Day, Year) 32. Registrar's Signeture Registra



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02686 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1999 =UDORA 28 Jamuary 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8. Dete of Birth (Month, Day, Yea 05-10-191 HARBOR ALT If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Yeer 9. Birthplace (Stete or Foreign Days Months Hours 1 □ M 2KDX 82 Yrs. 217-16-3272 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 20 No Maryland Anne Arundel Co. N/A 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 237 Berlin Avenue 21225 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Merried 2 Merried Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dometic 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Private. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumame) Hugh Coley Unknown 19a. Informant's Name/Reletionship (Type, Print) Robert Bradley, Jr./Son 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 237 Berlin Avenue, Baltimore, Maryland 21225 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dete Mt. Auburn Cemetery 4 □ Donation 5 □ Other (Specify) 2/4/99 Baltimore. Maryland 22. Name and Address of Facility William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Maryland 21217 Se, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest. List only one cause on each line. 21. Signature of F Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of) Due to (or as a consequence of): 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of

Physician /Medical Examiner

sician and burial-transit

physician street

Completed

Be

Certification: To

Medical

The law requires that the death certificate be axecuted

Box 68760

P.O.

Division of Vital Records.

or Attending Physician:

Hospital

eg:

this

in 24 hours after death.

The Funerat Director: After pletely filled in by the fur

within 24 ho To the Fune completely fi

Physician

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Examiner

10a. State

Director

Funeral

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Funeral

Director

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b

Berns 23a

8

Hygiene.

Pages 1 and 2 should be filled v nani of Health and Mental Hygie ant; if Ibem 27 is marked other I

Department of Health an important: If Item 27 is r kny injury or other traus

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Part II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part I.

28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier 29c. License number wreshi, Kesident Interna MEDICINE

29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

3001 SHANDUER STreet HOSPITAL CENTER HARBOR URESHI, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) MD 21225

State Registrar

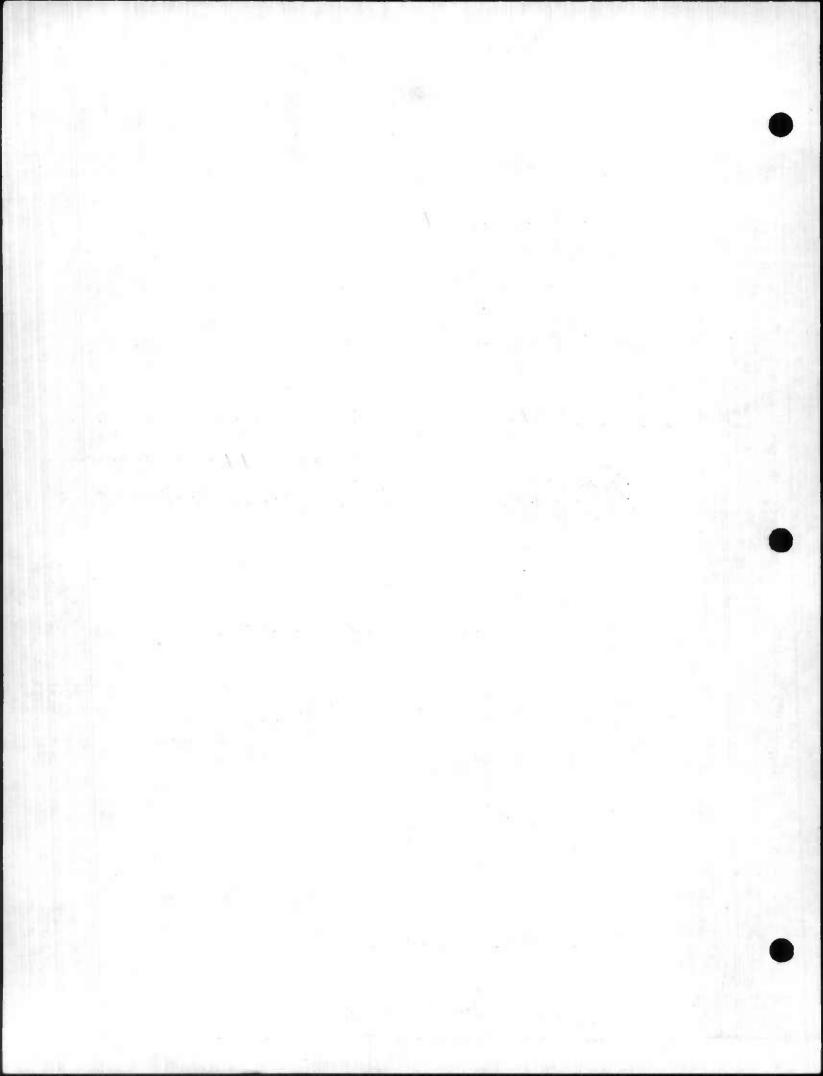
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5 Pending

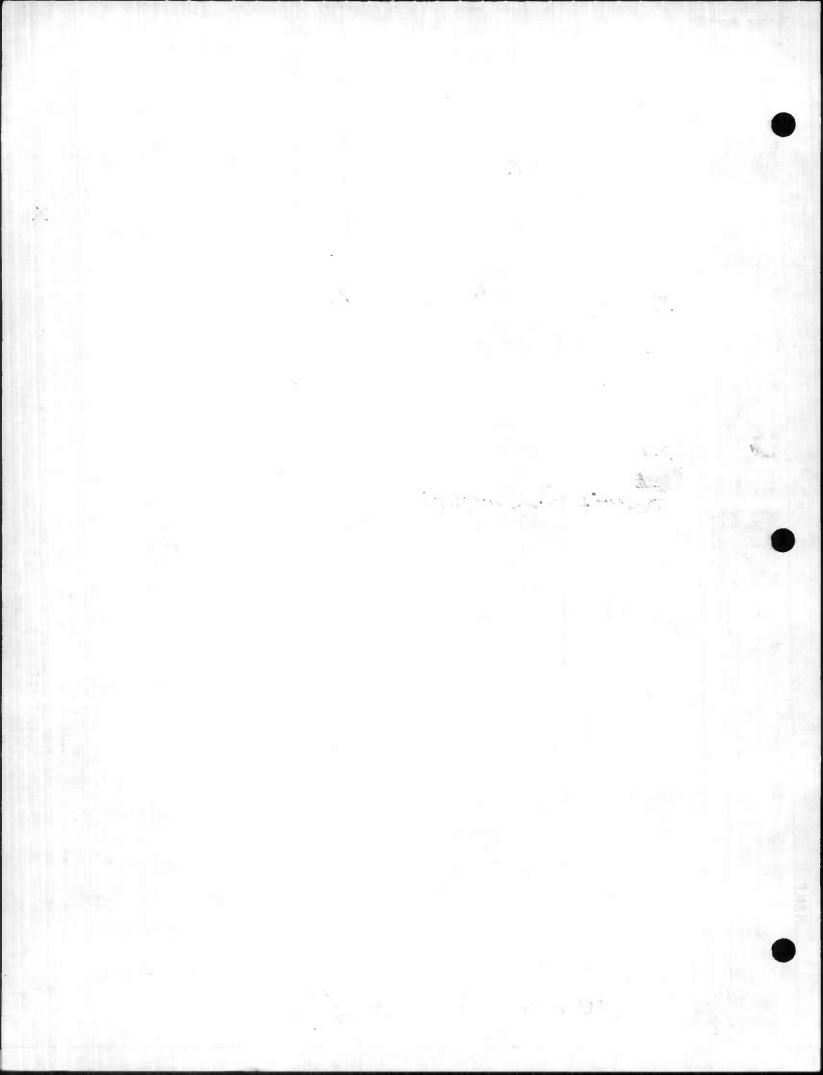
Investigation

6 Could not be determined



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ın			Cel	rtificate of	Dealli		Reg. No.	-	
al _	1. Decedent's Neme (First, Middle	ANN BAL	LARD			2. Date of De Month		1449	3. Time of Death
	4a Facility Name (If not institution,	, give street end number)			4b. City, Town, or I				
	ST. AGNES				BALTIMOF		N/		
		6. Sex 7. Age 1 M 2 F 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da			ce (State or Foreigny)
-	215 24 6405 Usual Residence of Decedent	74	113.			JUL.6,	1924	Sout	h Carol
-	10a. Stete 10b. County		10c. City, Town or Lo	ocation				10	d. Inside City Limit
ò	MD. BALT	CIMORE	RANDALI	CTOUN					1□ Yes 2XN
Director	10e. Street and Number	LITORE	KANDALI	10f. Zip Code		1	10g. Citizen of \	What Count	ry?
	9207 ALLENSW	NOOD ROAD		2:	1133		U.S. 0	F A.	
Lange	11. Meritel Stetus	12. Was Decedent E	ver in U,S. 13.	Was Decedent of I	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14. Rac	e - America	
	1 Never Married 2 Marrie	Armed Forces? 1 Yes 2 No if Yes, Give Yeer or Detes:	0	If Yes, specify Cub	an, Mexican, Puert Specify:	o Rican, etc.)	Specify	ck, White, e	
	15. Decedent		16a. Dece	dent's Usuet Occup	pation		16b. Kind of B		
Completed	(Specify only highest	t grade completed)	(Give	kind of work done DO NOT use retire	during most of word)	king			
5	Elementary/Secondery (0-12)	Rollege (1-4or 5+	CUS	STODIAN			HOTEL	4	
9	17. Father's Name (First, Middle, L	Last)			18. Mother's Nan	ne (First, Middle	, Maiden Suman	10)	
2	DOC BALLARI				ELLEN	LEMON			
	19e. Informent's Neme/Reletionsh		19b. Meilin	ng Address (Street	and Number or Ru	rat Route Numb	er, City or Town,	State, Zip (20001133
	MARY A. FITZO	GERALD (DAU	JGHTER)	9207 A	LLENSWOO	DD RD.	RANDAL	LSTO	WN,MD.
	20e. Method of Disposition		20b. Plece of Dispo	osition (Name of metory or other pla	ce)	Date	20c. Location -		
	1 Buriel 2 Cremation 4 Donetion 5 Other (Sp		MT. ZIO	ON CEME	TERY 2	6/99	BALTIM	IORE,	MARYLAN
	21. Signelure of Portirel Service L	EWIS T.	T-WYYV	2. Name and Addre	ss of Facility GWYNN	FUNERA	AL HOME	212	15-6393
+	23a Part 1 Enter the disease or	complications that cause t	the death. Do not ent	4517 PAI	RK HEIGH	ITS AVI	BAI		MD . Approximate
	23e. Part1. Enter the disease, or c shock, or heart feilure. List of	only one ceuse on eed Inc	9.	tor the mode or dy.	, 3001 03 041 04C	or reapiretory a	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Interval Between Onset and Death
	Immediate Cause (Final	DNE	HIMONIA					1	2 DAY
	disease or condition resulting in deeth)	8.	Due to (or as a consec	aneuce off.				1	d Dri
5			000 10 (0) 23 2 00/300	quarios ory.					
Lyaninic	Sequentielly list conditions.	b	Due to (or es e consec	quence of):					
	if any, leading to immediate							i	
	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury thet initiated events resulting in death) Leat Due to (or es a consequence of):							t	
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9	Ceuse (Diseese or Injury thet initiated events resulting In deeth) Last	D		1001100 017.				t	
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0	Ceuse (Diseese or Injury thet initiated events resulting in deeth) Last	d			ven in Part t.	23b. Did	tobacco use co	ntribute to	the cause of deat
Physician/Med	Part II. Other algnificant condittor	dna contributing to death but	not resulting in the u		ven in Part t.		tobacco use co Yes 2 No	ntribute to	
by Physician/Med	resulting in geeth) Last	dna contributing to death but	not resulting in the u		ven in Part t.	1	Yes 2 No	3 Prob	ably 4 Unkn
by Physician/Med	Part II. Other algnificant condittor	dna contributing to death but	not resulting in the u		ven in Part I.	1 🗆	1	3 Prob	ably 4 Unknown
of ruysiciansmen	Part II. Other algnificant condittor	dna contributing to death but	not resulting in the u		ven in Part t.	1 🗆	Yes 2 No	3 Prob	ably 4 Unkno
on maintained to	Part II. Other algnificant condittor	dna contributing to death but	not resulting in the u		ven in Part I.	1 🗆	Yes 2 No an autopsy omed?	3 Prob	re autopsy finding: ilable prior to apletion of cause
be completed by Physician/Med	Part II. Other algnificant condittor	d	not resulting in the u	inderlying cause gi	26. Place of Dec	1 □ 24a. Was perfe	Yes 2 No	3 Prob	re autopsy finding ilable prior to upletion of cause eath?
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o se completed by Physician/Med	Part II. Other algnificant condittor CEREBRO VAS CC. 25. Wes case referred to medical exeminer? 1 Yes 20 No 27. Mepner of Death 1 Netural 5 Pending	d	not resulting in the u	indertying cause git	26. Place of Dec ner: 4□ Nursing H ny et rk?	24a. Was perfect the state (Check only come 5 🗆 Resi	an autopsy med? Yes 2 (No	3 Prob	ably 4 Unknown to autopsy finding isable prior to upletion of cause eath? Yes 2 No
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02688 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Dav **Physician** Louisa Whildin Buchner February 1, 1999 6:50 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Union Memorial Hospital Baltimore n/a If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1□M 210 F Days Hours Yrs. 220-44-3159 Director 01-26-1906 Pennsylvania Usuel Residence of Decedent the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Mouical Examiner must be notified as 1 Yes 2 No Baltimore Maryland n/a Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 West 40th Street 21211 U.S.A. deeth v Funeral 12. Was Deceden! Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 200 No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Peges 1 and 2 should be filed within 72 hours effer or ent of Heelth and Mental Hygiene. nt: If Nem 27 is marked other than "naturel", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Years 4 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Evan T. Whildin Fenstermacher Kate 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Louisa B. McDonald (Daughter) 845 Fox Hill Lane Radnor, Pennsylvania other 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremetion 3 ☐ Removel from State 8 Department of Important: If eny Injury or price. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2/3/99 Towson, Maryland 22. Name and Address of Fecility Leonard J.Ruck, Inc. 21. Signature of Puneral Servica Licensee 5305 Harford Road Baltimore, Maryland 21214 J. Wayne Osterling , or complications thel caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one ceuse on each line. Approximate Interval Between Onsel and Death **Physician** /Medical Immedia disease or condition resulting in death) Examiner Examiner certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thal initieted events resulting in death) Lest Due to (or es e consequenca of): pue Records, P.O. Box 68760 attending physician for use as the bune Physician/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown Preumonia by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy MO SVT peen hes 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Neturel 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after deat 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) ■ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es steled.

2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and piace, and due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) D37(33

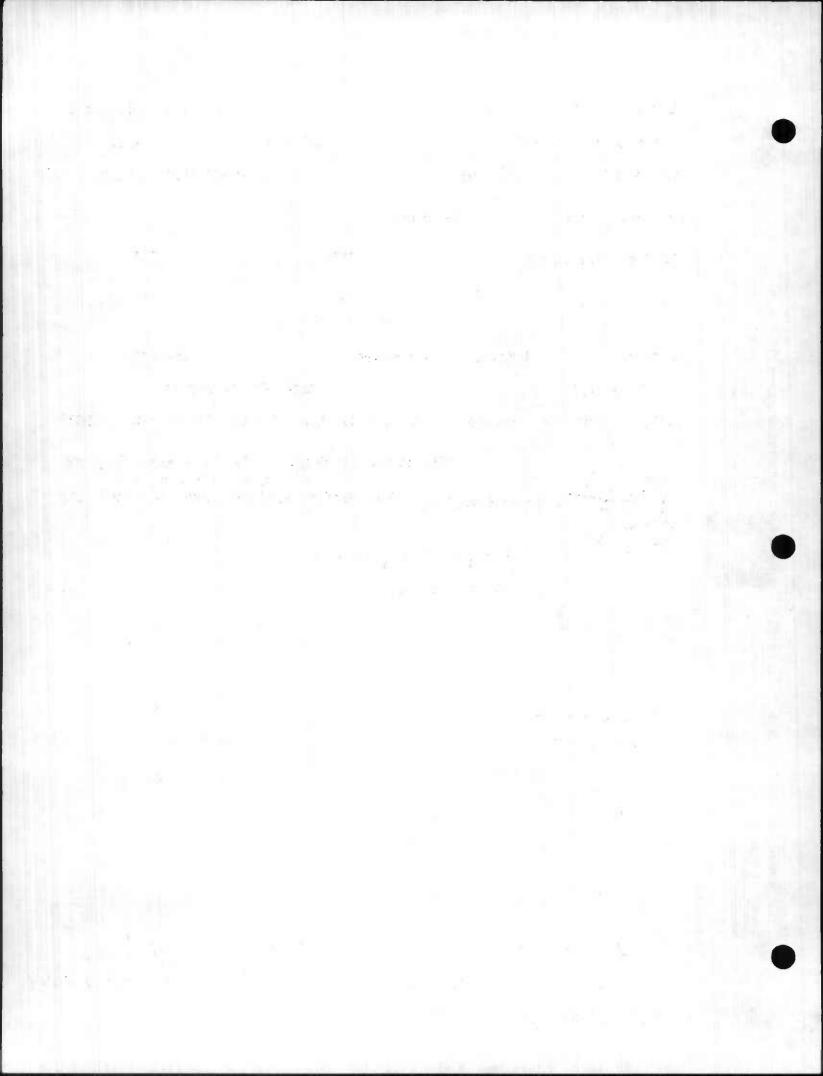
State Registrar

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31. Date filed (Month, Dey, Year) FEB 0 3 1999

7600 Oster Dring + 209 Towson, UD 21204 Dunna L. Dun M.D. 32. Registrar's Signature

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

O Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 209 AM Month STELLA BEELAT 1999 January 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Agnes Healthcare Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Days Hours 1□M 2♥F Months 215-07-4130 BALTIMORE, MD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39 SHADYNOOK AVENUE 21228 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Giva Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) Collega (1-4or 5+) 2 YRS 12TH GRADE HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) ADAM KALINAUSKAS MARGARET DELTAUVA 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 39 SHADYNOOK AVENUE - CATONSVILLE, MARYLAND 21228 EDWARD A. BEELAT (HUSBAND) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 XBuriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify MOST HOLY REDEEMER CEM 01/30/99 BALTIMORE, MARYLAND 21. Signature of Funeral Service Lice 22. Name end Address of Fecility
HUBBARD FUNERAL HOME, INC. mor 4107 WILKENS AVENUE - BALTIMORE, MARYLAND 21229 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest slock, or heart feilure. List only one cause on each line. Immediete Cause (Final 5EP515 diseasa or condition rasulting in deeth) HYPER DSMULAR HYPER GLYCEMIC MONKEDING 4 DR 73 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DIABETS MELLITUS Pert II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be determined 3 Sulcide 28e. Place of thiury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier

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State Registrar

Physician

/Medical

Examiner

Funeral

Director

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rail, or items 23s or 28s-f shore Examiner must be notified at

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Department of Important: If any fnjury or pace.

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Completed

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Certification: To

Pages 1 and 2 should be

Director

Funeral

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Completed

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the Maryland

72 hours after

21215-0020

Baltimore, Maryland

31. Date filed (Month, Day, Year) FEB Q 3 1999

(Check only one)

29b. Signature end titla of certifier

OBENG

RESIDENT.

P-12598

BALTIMORE, MD

29c. License number

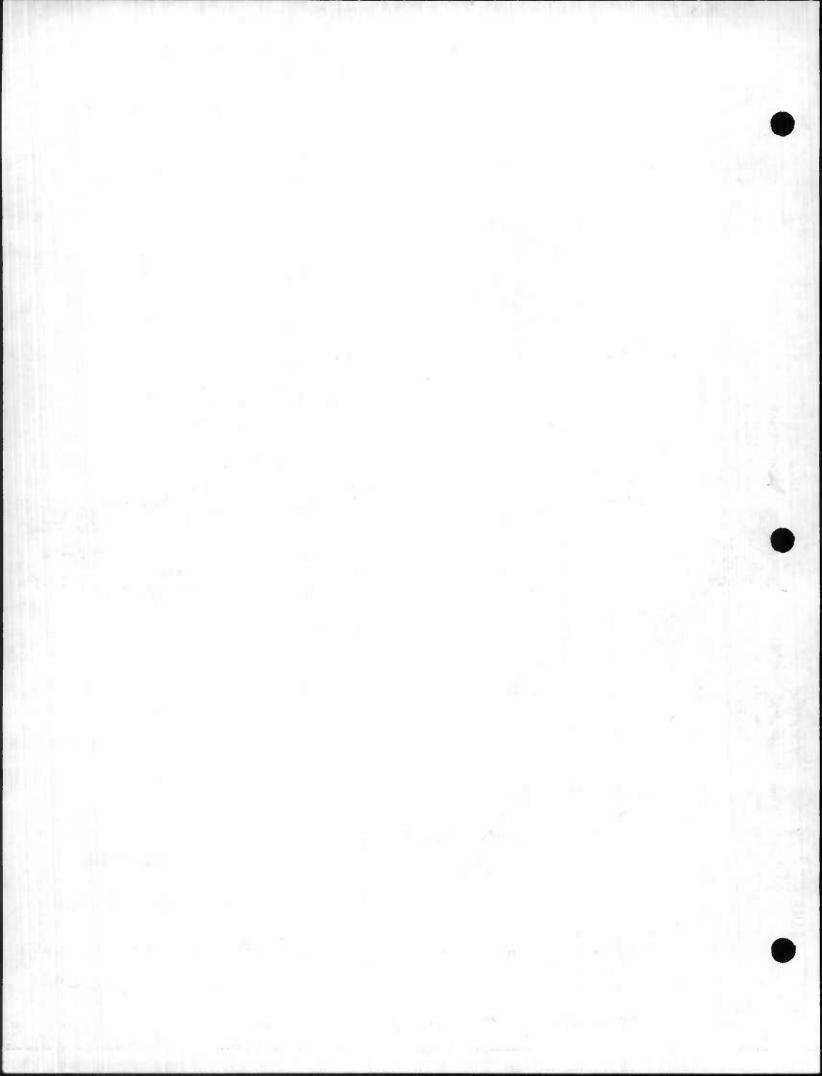
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATOM

SIMEON 32. Registrer's Signeture

Director

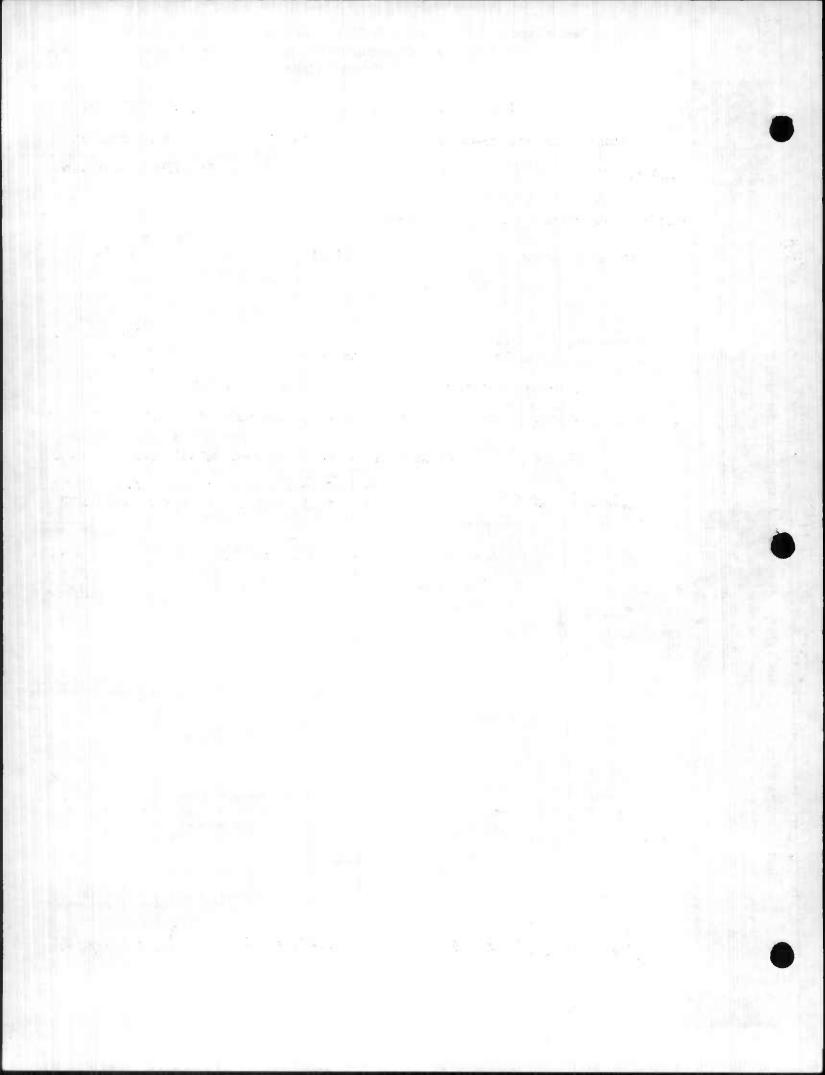


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of	Maryland /	Department	of Health and	Mental Hygiene
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			eme (First, Middle	e, Last)						2. Date of De	ath		3. Time of Death
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	/Medica Examine	An English Man	e (If not institution	n, give street and		_	-		4b. City, Town, or	Location of Deat	4c. County	of Death	
	Examine		tlantic (General :	Hospita	1			Berlin		Worce	ester (20.
	Funeral Director	5. Social Securit 219-14-	-2258	6. Sex 1 ☑ M 2 ☐ F	7. Age (In y			nder 1 Yee ths Days		8. Date of Bir Month, Da April	14°,1925	9. Birthplace Country Mally	e (State or Foreign land
	pug *	Usual Residence	10b. County		10c.	City, Tow	n or Location					10d	. Inside City Limits
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0433	w 23	35 SE	abreeze		ecedent Ever in	IIS	13 Was Di			Specify Yes or No		e - American	Indian.
20	be filed within 72 hours after death with the Meryland lall Hygiene. d other than "natural", or items 23a or 28e-f show event, the Madrell Examination must be notified. Re Commission by Espace Director	3 ☐ Widowe	arried 2√2 Marr d 4 Divorced	Armed 1 D Ye If Yes,	Forces? s 2 □ No W Give r Dates:			specify Cul	Hispanic Origin? (S ben, Mexican, Puerl Specify:	to Rican, etc.)	Specify	ok, White, etc	
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yound 1-	and 2 should be talth and Ments of 72 is marked or traumatic or		Name/Ralations Cavey		Son	45	50 Gair	nsbor	ough Ct.	ural Route Numb Severna	er, City or Town, Park, Ma	Stata, Zip Caryland	21146
altimore.	permit. Pages 1 and 2 Department of Haalth a Important: If item 27 is any injury or other tra once.	20a. Method of D 1 ☑ Burial 4 ☐ Donatio		3 □Removal fro	m Ctata	cemete	f Disposition ry, crematory SVILLE	or other pl	emetery J	Date [an. 29,1]	20c. Location		
	y Injection	21. Signature of	Funeral Servica	Licensee			22. Nam	e and Add	ress of Facility olyniak F	unoral	Jomo D 7		
7 Cha	88188	1	117	111:					tain Road				L122
4-25	PERMIT	23a, Part1 Entr	or the disaese, or	complications that	at causad tha d	aath. Do	not antar the	mode of dy	ring, such as cardia	c or respiratory a	rrest,	. A	pproximata iterval Between
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7	/Medicai	Immediate Caus disease or cond	sa (Final		Coco	200	4+00	11	FAL C	URE		1 2	3 days
0	Examiner	resulting in deat	th)	a	Dria to	oforasa	consaquence	off:	/ //				20.(13
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()	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeré Director: After thi completaly filled in by the funeral	29a. Certifier (Check only one)		Examiner: On the					tima, date and place opinion, daath occ				
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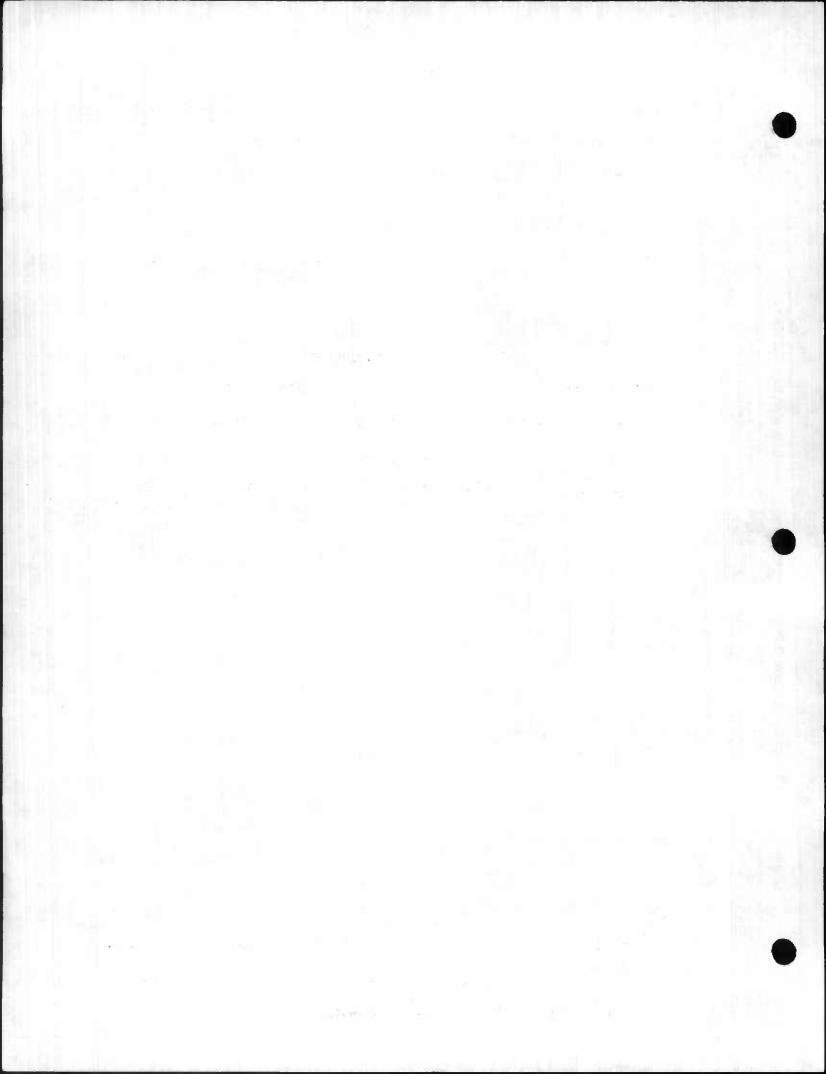


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day **Physician** Martha Crowe 24, 1999 4c. County of Death 4b. City, Town, or Location of Death 9:40 A.M. /Medical 4a Facility Nama (If not institution, give street and number) Examiner Harbor Hospital Center Baltimore If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 10 M 20XF Months 213-22-3815 Director March 12, 1926 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic ayant, the Medical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò permit. Pages 1 and 2 should be filed within 72 hours aftar death w Department of Heelth and Mentai Hygiena. Important: if Itam 27 Ia marked other than "natural", or items 23a of any Injury or other traumatic avant, the Hedge Emminion 23a of any 726 Wedeman Avenue 21225 U. S. A.

14. Race - American Indian, Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th 0 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 Clarkson Dunn Goldie Kisner 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George L. Crowe, Sr. (Husband) 726 Wedeman Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slata 1 D(Burial 2 Cremetion 3 Removal from Stete 4 □ Donation 5 □ Other (Specify) Crest Lawn Mem. Gardens 1/28/99 Marriottsville, Maryland 21. Signeture of Funeral Service Licensee Ecker McCully-Polyniak Funeral Home P.A. Kevin E. 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete tnterval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) tic Cardiovascular Disease Examiner Examiner The law requires that the death certificate be asscuted physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical Dua to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yes 2 No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. tnjury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29b. Signatu/p and title of certifier 29d. Date signed (Month, Day, Year) 126203 27/99 address of person who completed cause of death (Item 23a) (Type, Print) 4000 Annapolis Rd Baltimore 21227 Vallecillo 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State FEB 3 1999 Registrar



					-	Certifi	cate of	Death		Reg. No.	_	
г	Physici	ian	1. Decedent's Nama (First, Mid Mary L	die, Lasi) Combs					2. Date of Dea Month	Day	9981	3. Time of Death
	/Medi							n 02 7 - 1	Feb			3:20 am
à	Examir	ner	4a. Facility Name (If not institute 238 Orvil.		n <i>ber)</i>			4b. City, Town, or L Essex	ocation of Death	,	cimore	9
	Funeral Director		5. Social Security Number 218–36–1273	6. Sex 1 □ M 23乙 F	7. Age (In yrs. Ias 59		Under 1 Yaar nths Days		8. Date of Birth (Month Day April 4	20°°1939	9. Birthpli Count PA	ace (State or Foreign try)
	and *		Usual Residence of Decedent 10a. State 10b. Coun	tv	10c. City.	Town or Location	n				10	Od. Inside City Limits
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020	or ite	by	11. Marital Status 1 □ Never Married 2 ◯ M. 3 □ Widowed 4 □ Divorce	arried 1 Yas	8		Decedent of , specify Cul es 20 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yas or No- Rican, etc.)	14. Rad Bled Specify	e - America ck, White, e	
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/lan	should be filed wind Mental Hygien marked other th	To Be	Leroy Mor					Mari	an Wals	sh	3.74	
M	an an		19a. Informant's Name/Reletio Billy J.Combs					t end Number or Ru 1e Road			State, Zip	
Baltimore,	permit. Pages 1 end Department of Health Important: If Item 27 any injury or other to once.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other		20b. Pla cen Sac	ce of Disposition netery, cremator red Head	(Name of y or other plant rt Of	Jesus 2/	Date 5/99	20c. Location - Baltin		
Balt	permit. Pages Department of I Important: If Its any Injury or or once.		21. Signature of Funeral Sarvio	e Licensee	11.	Con	nnelly	ess of Facility Funeral Ave. Bal				
	Physician /Medicai Examiner	J	23a. Part 1. Enter the disease, shock, or heart feilure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cause on ea	Due to (or a	ldiga	du .	Pulmine			- 8	Approximete Interval Between Onset and Death
ox 68760,	n certificate be executed and onding physician and use as the burial-transit	√Medical Examiner	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Lest	b		s a consequence					-	
). Box	deeth e atte	Physiclan/N	Part II. Other significant condi-	tions contributing to dea	ath but not result	Ing in the underly	ying cause g	iven in Part I.	23b. Did t	obacco use co	ntribute to	the cause of death
9, P.O	requires that the deeth een signed by the atter hould be deteched for u	by Phy							101	ree Kho	3 Prob	ebly 4 Unknow
Records,	aw 2 s b	Completed t								an autopsy med?	ava	re autopsy findings illable prior to apletion of cause death?
œ	The ate t	Сош							101	as GENo	1□	Yes 2 No
V ta	Physicien: The ribis certificate ral director, page	Be	25. Was case referred to medic examiner?	Hospital:				26. Place of Dea	11			
on of	ing Phys I. After this funeral di	lon: To	1 Yes 2 No 27. Menner of Deeth Natural 5 Pend	28a. Date o (Montif	·	8b. Time of Injury	28c. Inju	iry at ork?	ome 5 Resid	lence 6 Oth		')
Division of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Coul	mined 289. PI609	of Injury - At hom g, etc. (Specify)	e, ferm, straet, f]Yes 2□No	28f. Location (S City or Tow		per or Rumai	l Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29e. Certifier 110 Certify (Check only one) Medica	ing Physician: To the batter than the batter to the batter	sis of examinetion	edge, death occu n end/or investig	urred at the t jetion, in my	ime, date and place, opinion, death occur	and due to the orred at the time,	ceuse(s) and madate and plece,	anner as sta end due to	ated. the cause(s)
	To the Within To the comple	Me	29b. Signature and title of certif	-	0		29c. Licen	se number		29d. Date signe	d (Month,	Pay, Year)
			Hano	Wal	6 fu	n	20	6835		21	2	99
	7		30. Name and address of person Dr. Paul N					nt Road	Balti	more M	d. 2	1224
	Sta Registr		31. Date filed (Month, Day, Yea		gistra Signatu	° 4	1.					

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked othe any lojury or other treumatic event ang lojury or other treumatic event ange.

Physician

/Medical

og physician end es the burial-transit

USB jo

signed by the e

peen page 2 s certificate has

After this luneral

the f

filled in by

requires that the death certificate be executed

Hospital or Attending Physician:

death.

after death Director:

To the Hospital within 24 hours a To the Funerel Completely filled

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Completed

Be

70

Certification:

edical

Examiner

Director

Funeral

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EORGE			State of Maryland	/ Department of Health and N Certificate of Death	Mental Hygiene 9 9	0269
ONLEY	ITEMS: #23 PAR	T I. 27.	28A-F PER MEO G768	Certificate of Death	Reg. No.	

10c. City, Town or Location

Baltimore

GEORGE	TTEMC. #22 DADT I		of Maryland 2 Uepg	rtificate of	Health and		
CONLEY Physician /Medical			ix ried droo	tinouto oi	Bouin	2. Date of Deeti Month JANUARY	Day
Examiner	4 - 10 - 104 - 54 217 4 2 426 -		umber)		4b. City, Town, or BALTIMO	RE	4c. C
Funeral Director	5. Social Security Number 219-62-0021	6. Sax 1 1 M 2 □ F	7. Aga (In yrs. last birthday) 45 Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs s Hours Min	O. DOLO OI DILLI	Year) 20 19
	Usual Residence of Decedent				-		

4c. County of Death n/a

1999

3. Time of Death

8:44A.M.

 Birthplaca (Stata or Foreign Country) 1953 Maryland

10a. Stata 10b. County Md. n/a 10e. Street end Number

10d. Inside City Limits 1 Yas 2 No

1416 Marshall Street

10f. Zip Coda 10g. Citizan of Whet Country? 21230 USA

14. Reca - Amarican Indien, Black, Whita, atc.

11. Maritel Status 1 Navar Married 2 Married 3 Widowad 4 Divorcad

13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 12. Was Decedant Evar in U,S Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Year or Datas:

1 ☐ Yas 2 ☑ No 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired)

Specify white 16b. Kind of Business/Industry

15. Decedant's Education (Specify only highest grada complated) Elamantary/Secondary (0-12) 11

Collega (1-4or 5+) 0

(Wife)

Longshoreman

Local 333

17. Fethar's Nama (First, Middla, Last)

George W. Conley, Sr.

18. Mothar's Name (First, Middle, Maidan Sumame) Elizabeth Hartlove

19a. Informant's Name/Ralationship (Type, Print)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)

Ruthann K. Conley

20b. Placa of Disposition (Nama of cemetary, cramatory or other plece)

1416 Marshall Street, Baltimore, Md. 21230 20c. Location - City or Town, Stata Feb. 04

20a. Mathod of Disposition 1 Burlal 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify)

New Cathedral Cemetery

Baltimore, Md.

21. Signature of Funarel Sarvica Licansaa

22. Nama and Addrass of Facility
McCully-Polyniak Funeral Home P. A.

1999

)	1	ere	3.	Eld
23a.	Par			complications th

nat causad tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, on each line.

130 E. Fort ave. Baltimore, Md. 21230 Approximata Intarval Batween Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

NARCOTIC INTOXICATION

Dua to (or as a consequence of)

Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last

Dua to (or as a consequence of):

Due to (or as e consequenca of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Onknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to evallable prior to complation of causa of daath?

1 Vas 2 No

25. Was casa rafarrad to medical axaminar? 1⊠ Yas 2□ No

27. Mannar of Death

1 Natural

2 Accident

3 ☐ Suicida

4 Homicida

28a. Data of Injury (Month, Day Yaar) 5 Panding Invastigation UNKNOWN

6 Could not be

28b. Tima of Injury UNKNOWN

28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Spacify)

UNKNOWN

1 Yas 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

UNKNOWN

26. Placa of Daath (Check only ona)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) UNKNOWN

29a. Certifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signatura and titla of cartifia

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

FEBRUARY 1,1999

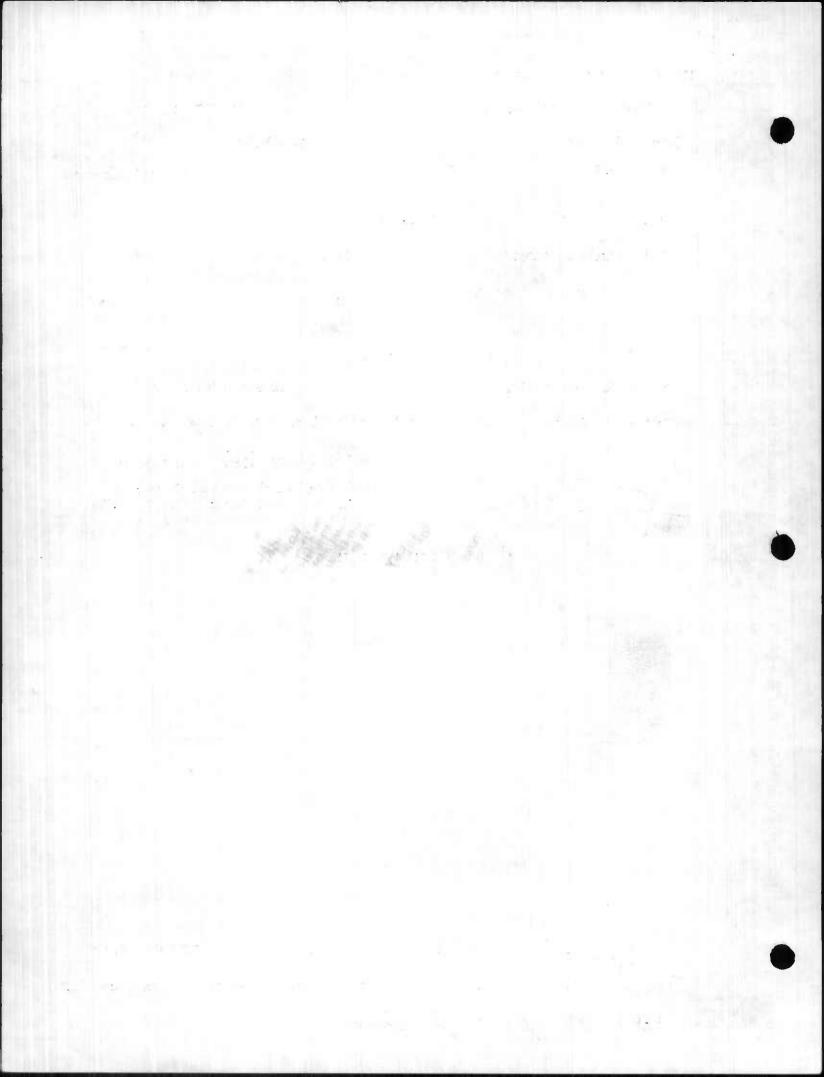
30. Nama englade who complated causa of death (Itam 23a) (Type, Print) rass of person

100 Month, Day,

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Ragistrar's Signatura

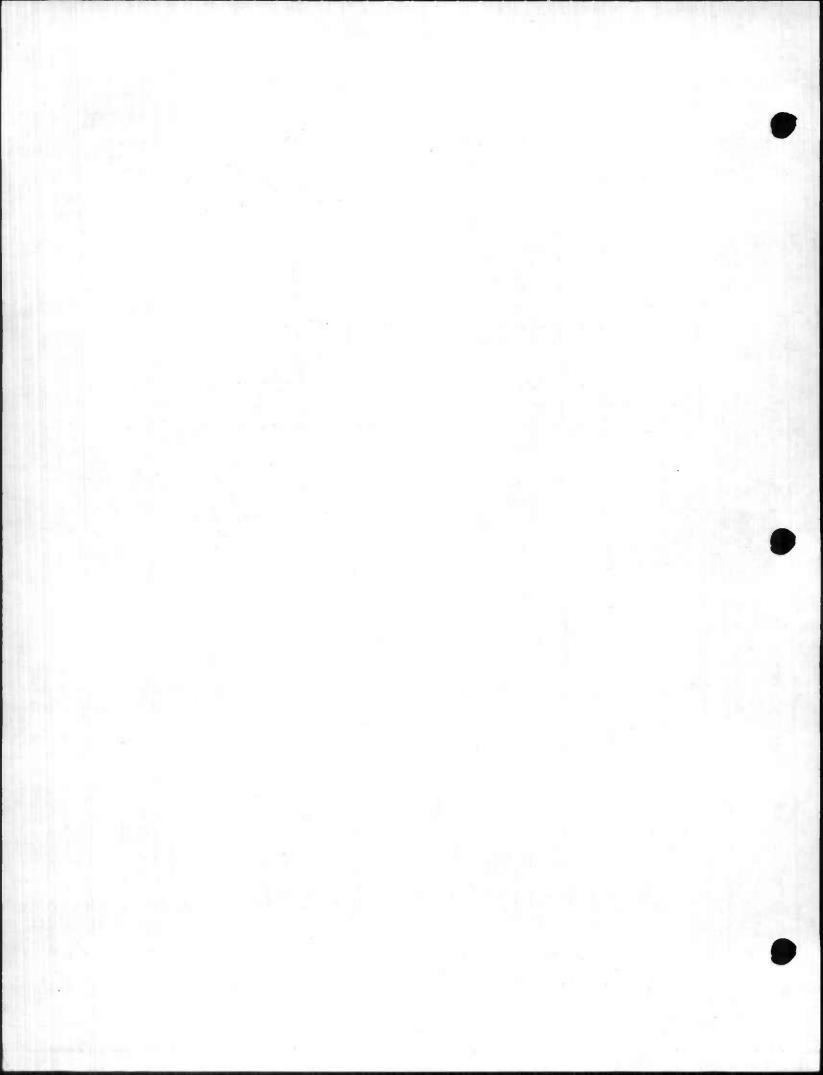


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** Dwight Collmus 4b. City, Town, or Location of Death 26, 1999 4c. County of Death 9:15 PM /Medical 4a Facility Nama (If not institution, giva street and number) **Examiner** Homewood At Frederick Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 1₽M 2□ F Months Hours 74 217-18-7469 Yrs Director 1924 Maryland 2, Usual Rasidence of Decedent the Menyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 Yas 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after deeth with Department of Health and Mental Hygiene. Important: If Itam 27 Ia marked other than "natural; or itama 23a or: any injury or other traumatic avant, the Medical Exemples. 212 Rockwell Terrace 21701 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Giva 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry College (1-4or 5+) 5+ Elementary/Secondery (0-12) Investment Banker Bank 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Nina Louise Hunnicutt Albion Burnett Collmus 0 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 212 Rockwell Terrace, Frederick, Maryland 21701 Serene Collmus/wife 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 ☐ Other (Specify) Ronal Service Licensea 22. Nama and Addrass of Facility State Anatomy Board, 655 W. Baltimore Street /Wade, Director Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete tritarvat Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical 1-21m ge con Examiner Due to (or as a consequence of): Examiner sicien and burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseasa or injury that initiated evants rasulting in daath) Last Due to (or es a consequence of) physicien s the burial Box 68760. Physician/Medical Dua to (or as a consequence of) 60 980 signed by the at d be deteched for P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Division of Vital Records. 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? should Completed 99 1 Yas 2 No certificate 1 ☐ Yas 2 ☐ No or Attending Physician: director. 25. Was casa rafarred to medical axaminar? Be 26. Place of Deeth (Check only one) Other: 4 Qursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28c. tnjury at Work? Natural 5 Pending 1 ☐ Yas 2 ☐ No 24 hours after death.

Funeral Director: A investigation 2 Accident 6 Could not be 3 Suicida 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and menner as stated.

| Continued on the cause of the 29a, Cartifier completely (Check only one) within 2 ş 29b. Signatura and titla of certifian 29c. License numbe 29d. Data signed (Month, Day, Year) 0 ed cause of deeth (Item 22a) (Type, Print) 30. Name and a es of person who compl Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02695 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** oleman manue /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Merci laris a If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F 64 Yrs. 218-30-6743 Director Jul 21, VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MD N/A BALTO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is married other than "natural", or ferma 23a or any Injury or other traumatic event, the Medical Exercise 2008. 1419 Darley Ave 21213 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritai Stalus NOWes 2 No ft Yes, Give 1 ☐ Never Merried 2 ☑ Married 1 Yes XIXNo Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Oleman, Emanue Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Fire Dept 12th Fireman 2yrs 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Coleman R. Britton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Beverly Coleman 1419 Darley Ave Balto, Md 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 2-5-99 Garrison Forest Owings Mills, Md 4 ☐ Donation ☐ Other (Specify) neral Service License 22. Name and Address of Facility Betts Funeral Home 1129 N. Caroline st Balto, Md 21213 rus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Physician/Medical Examiner physician and the bunaf-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or as a consequence of) 980 signed by the a Part tl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably Qunknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 26. Place of Death (Check only one) STE//A MARIS AT MERCY 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 25 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? 1 Waturat or Attending 5 Pending investigation i after death. ii Director: Aff id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funerii Di completely IIIed is Medical 29a. Certifier Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

31. Date filed (Month, Day, Year) FEB 3

Registrar

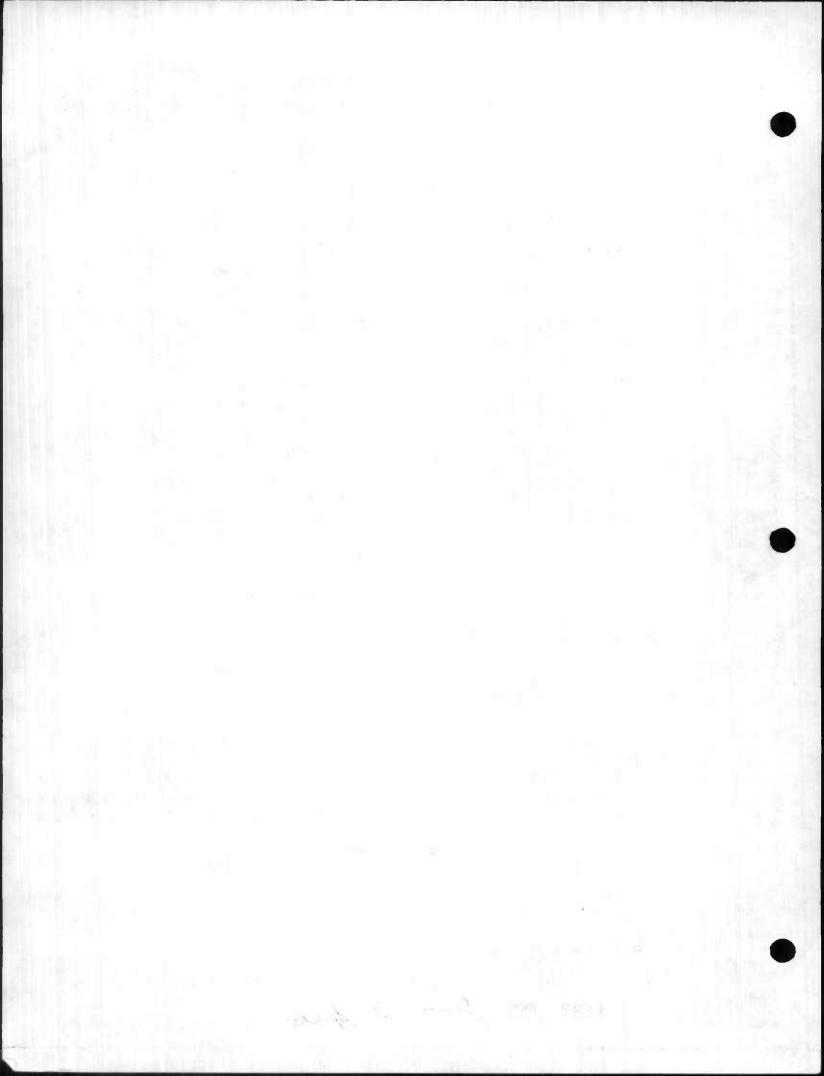
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

1999 32. Registra Signature

D40854

Baltimy, MO

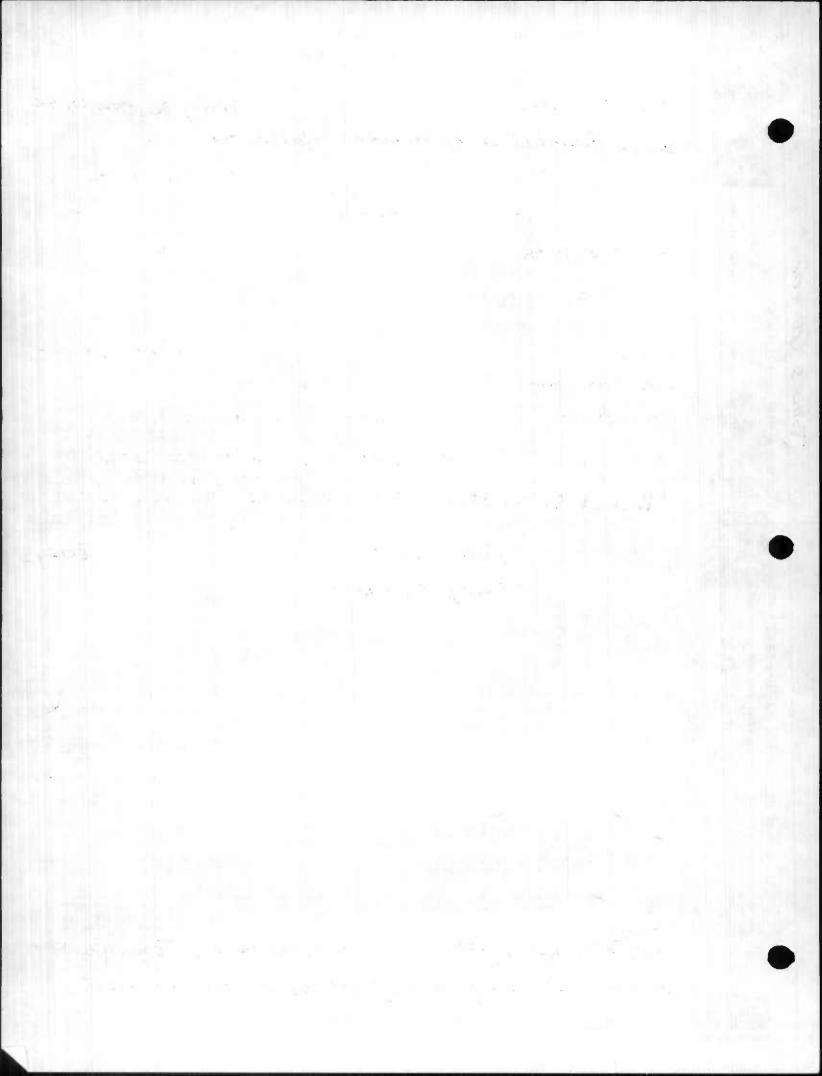
21202



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Dete of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 0140 **Physician** James Wallace Carter anuciny 30 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) Examiner Baltimore Hospital Sinas 5. Social Security Number If Undar 1 Yaar Under 24 Hrs. Aga (In vrs. last birthday) Birthplace (State or Foreign Country) Months Hours XXM 2DF 78 Yrs. 218-03-1029 Director March 24, 1920 Md. Usuei Rasidenca of Decedent the Marylend 10a Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits r 28a-f show 1 Xas 2 No Md. n/a Baltimore Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 7 is marked other than "natural", or items 23a or traumatic svent, the Medical Examiner must be a 4005 Oakford Avenue 21215 USA deeth Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Rece - Amarican Indian 11. Marital Status Black, White, atc. hours after L□Yes 2□No KYes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: by 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use refired) 16b. Kind of Business/Industry 2 should be filed within end Mental Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Edgewood Arsenol Federal Government 12th Grade 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) James Oscar Carter Mary Holmes 19e. Informent's Neme/Reletionship (Type, Print) wife 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 sh Department of Health end Important: If Itam 27 is m any Injury or other traum ance. Georgia Carter 4005 Oakford Avenue Baltimore, Md. 21215 20b. Place of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition Buriel 2 Cremetion 3 Removal from Stata Feb. Laurel, Md. 4 □ Donetion 5 □ Other (Specify) National Memorial Park 22. Nama end Address of Fecility Nutter Funeral Homes, Inc. 21. Signatura of Funaral Service Licenses 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shook, or heart feilure. List only one cause on each line. Onset end Death **Physician** 8 days Immediate Ceusa (Final disease or condition resulting in deeth) Preumonia /Medical Examiner Cancer Examine end -transit death cartificate be axecuted Sequentielly ilst conditions, if eny, leading to Immediata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest physician e P.O. Box 68760, Physician/Medical Dua to (or es a consequance oi): 98 USB signed by the a 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Ware autopsy findings available prior to complation of cause of death? 24e. Was an autopsy performed? Completed cartificate has b 1 ☐ Yes 2 No 1 Yes 2 20No Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? Aftar Naturel 5 Pending 1 Yes 2 No deeth. investigation 2 Accident ofter deet Director: 6 Could not be determined 3 ☐ Suicide 28a. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 124 hours efter Ne Funeral Direct Intately filled in b 4 | Homicide ŏ 12 Cardifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end mennar stated. 29e. Certifier edicai (Check only one) To the I within 2 29b. Signature end title of certifian 29c. Licansa number 29d. Dete signed (Month, Dey, Year) 452402321 DK919 30. Neme end eddress of person wh use of deeth (Item 23a) (Type, Print) mickautman 2401 W. Scheders Ale, Baltmore, 40

State Registrar 31. Dete filed (Month, Day, Year)

32. Registrar's Signeture



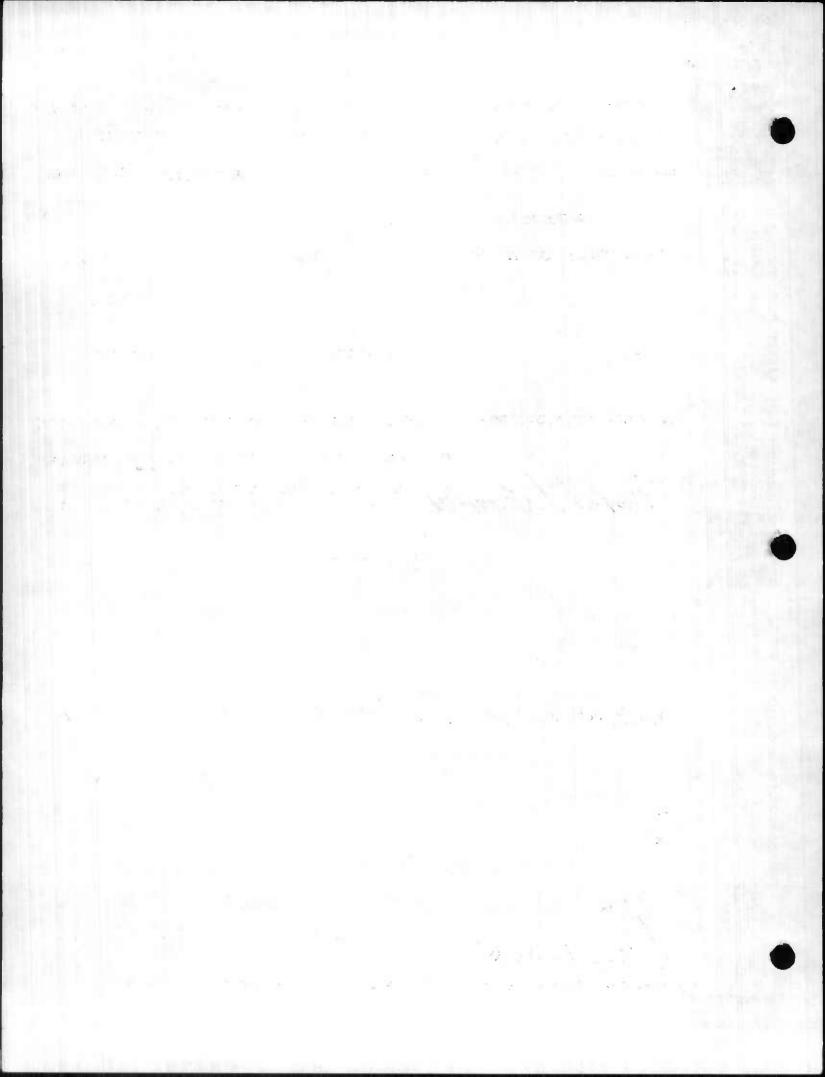
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	0		1. Decedent's North	a (First, Middle, Las	el		00	rtifica	ie or i	Dealli		2. Data of D	Reg. No.		3. Tima of Death
	Physician /Medica	n	VIVI		DUKES							JAN.	29, 19	99	6:00AM
	Examine			If not institution, give N SQUARE					4	ESSE		ocation of Dea		unty of Death LTIMORE	
	Funeral Director	2	5. Sociel Security N 218–60–92	26	x	Aga (In yrs.	43 yrs.	If Unde Months	Days	If Undar Hours	24 Hrs. Min.	8. Data of Bi (Month, D	rth ay, Year) 8,1955	9. Birthp Cour CAL	pleca (State or Foreign ntry) IFORNIA
	4 ahow		Usual Rasidanca of 10a. Stata MD	Dacedant 10b. County BALTIM	ORE	10c. Cit	ty, Town or Lo		T					1	10d. Inside City Limits
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020	F	by rur	11. Maritel Status 1 Nevar Marri 3 Widowad	iad 2□ Married 4 🎇 Divorced	12. Was Decede Armed Force 1 Yas 2 If Yas, Give Year or Data	is? DNo		Wes Dace If Yas, spe 1 Yas		ispanic Ori en, Maxicar Specify:	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)		ace - Amaric ack, White, ify: WHIT	cen indian, etc.
21215-0020	iene. r than "natural", r was cal Ex	Completed	Elementery/Seco	15. Decedant's Ed cify only highest grad endery (0-12)	ucation de completed) College (1-4	or 5+)	life.	DO NOT	ork done use retired	during mos	t of work	sing	16b. Kind of		
land 2	d oth		10 17. Fathar's Name (UNKNC	(First, Middle, Last)				HOUSE	WIFE		er's Nam		DX e, Maiden Suma	OMEST] ume)	IC
Σ	alth er 27 ia r trau			ame/Ralationship (7 NN TYLER/			602 A	A CAR	ROLL	and Number			ber, City or Tow		O Code) AND 21220
	permit. Pages 1 an Department of Haali Important: If Item 2 any Injury or other pnce.	2		position Cramation 3 Othar (Specify		. (Place of Dispo cemetery, cre AK LAWI	matory or	other place	Y	2	Dete 2/1/99	20c. Location		own, Stata MARYLAND
	hysician	1	23a. Part 1. Enter the shock, or haa	ha disaasa, or comp rt failura. List only o	lications that cau	sad tha daal	- 62	224 E	ASTE	RN AV	ENUE	SON,	IMORE. N	ARYL.	AND 21224
- 1	/Medical Examiner		immediate Causa (disaasa or condition resulting In death)	Finai	e		or as a conse	12-4	ra		Cardiao	or respiretory	errest,		Intervel Between Onsat and Death
28/60,	Medical Examiner and physician and stransit	edicai Examiner	immediate Causa (refinal in mailtions, madiata rhying injury	ebd	Dua to (c	or as a consector as	quence of)): :		Cardia	or respiretory	eriest,		Intervel Between
F.O. Box 68/60,	mar the death before a pasculed with the effective as the burial-fransit datached for use as the burial-fransit	Physician medical Examiner	immediate Causa (disaasa or condition resulting in death) Sequantially list con if any, laading to im- causa. Enter Unde Causa (Disaasa or that initiated avants rasulting in daath) L	refinal in mailtions, madiata rhying injury	ebd	Due to (c	or as a consec	quence of) quance of) quance of)): :	en in Pert		23b. Dic			Intervel Between Onsat and Death
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or Vital Records, P.O. Box 68/60,	injancian: The law requires that the cean cernicets be associated with this certificate has been signed by the ettending physician and an idirector, page 2 should be datached for use as the burial-transit and To Be Completed by Dhysician/Medical Examiner	To be completed by Physician/Medical Examiner	immediate Causa (disaasa or condition resulting in death) Sequantially list configure, laading to improve the causa. Enter Under Causa (Disaasa or that initiated avants rasulting in death) I. Part II. Other significations.	red to madical No h 5 Pending invastigation 6 Could not be	b c d which in to deat Hospital: 1 Inp 28e. Data of Information (Month,	Dua to (control to to to to to to to to to to to to to	or as a consection as a consec	quence of) quence of) quence of) quence of) anderlying Displant M	causa giv	26. Place	I. e of Daa	23b. Did 1 24a. Wa per th (Check only) oma 5 □ Raa 28d. Dascribe	d tobacco uss c Yes 2 No s an autopsy formed? Yas 2 No one) sidanca 6 0 how injury occ	3 Pro 24b. W av cc of	Intervel Between Onsat and Death Obebly Unknow Vere autopsy findings validable prior to ompletion of cause of death?
Islon of Vital Records, P.O. Box 68/60,	Agath, Cast, After this certificate has been signed by the ettending physician and core. After this certificate has been signed by the ettending physician and y the funeral director, page 2 should be datached for use as the burial-transit or filtration: To Be Completed by Dhysician Medical Examiner	Cermication: To be completed by Physician/Medical Examiner	immediate Causa (disaasa or condition resulting in death) Sequantially list confidency, laading to improve the causa (Disaasa or that initiated avants resulting in death) I. Part II. Other eigniff 25. Was casa refarrexaminer? XIX Yas 2 2 27. Mannar of Death Saladian of Death 3 3 Suicide 4 Homicida	red to madical No h 5 Pending invastigation 6 Could not be determined	e	Dua to (contract to the but not reserved to (contract to the but not reserved	or as a consection as a consec	quence of) quence of) quance of) inderlying int 3 D	causa giv	26. Place ar: 4 No.	I. e of Daa ursing H	23b. Dic 1 24a. Wa period 24a. Wa 24a. Wa 24a. Wa 24b. Dascribe 28f. Location City or To	I tobacco usa of yes 2 No san autopsy formed? I Yas 2 No one) I Yas 2 No one) I Yas 2 No one) I Yas 2 No one) I Yas 2 No one) I Yas 2 No one) I Yas 2 No one)	3 Pro 24b. Wall and compared or service of service or	Intervel Between Onsat and Death Onsat and Death Onsat and Death Onsat and Death Onsat and Death Onsat and Death Onsat and Death Onsat and Onsat a
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State Registrar

31. Deta filed (Month, Day, Year)

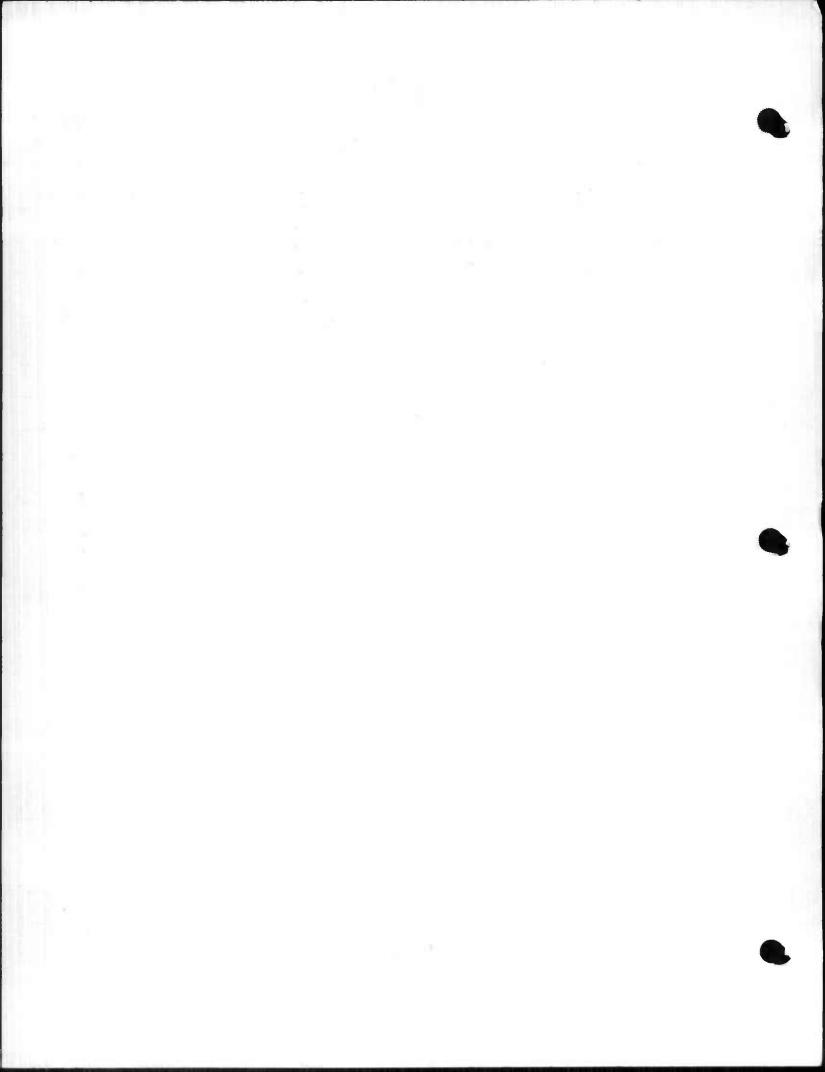
111 Penn Street, Baltimore, Maryland 21201



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or remoral. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	C	ERTIFICATE	OF DEAT	TH		REG NO

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.						
14	1. OECEDENT'S NAME (First Allother Last)	DiPESA		2. DATE OF DEATH DAY JAPAN 3. TIME OF DEATH A.			
Y FUNERAL DIRECTOR		S. SEX 6. AGE (In yrs. last bird	thday) IF UNDER I YEAR YRS. MONTHS DAYS	IF UNDER 24 HRS. HOURS MM.	7. DATE OF BIRTH (Month, Day, Year)	925 a. Britin	IPLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give etree FOREST HAVEA	t and number)	96. CITY, TOWN O	SVILL	EATH /	9c. COUNTY OF D	
	10a. STATE 10b. COUNTY	TIMORE 10	DC. CITY, TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
	315 INGLES		101	ZIP CODE		10g. CITIZEN OF V	1 YES 2 NO
	11. MARITAL STATUS 1 Never Merried 2 Merried	2. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	13. WAS DEC	ecity Cuben, Mexica	IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	Bleck	E — American Indian, k, White, etc.
ED BY	\$ ☐ Widowed 4 ☐ Divorced 15. DECEDENT'S EDUCAT	TION 16a. DECED	PENT'S USUAL OCCUPATION	N N		SINESS/INDUSTRY	PHITE
COMPLETED	(Specify only highest grade co.	College (1-4 or 5+)	ind of work done during mo: NOT use retired.) PBOLE (—	st of working	STEE	1-	
	17. FATHER'S NAME (First, Middle, Last)	UKNOWN		18. MOTHER'S NA	ME (First, Middle, Maiden		
TO BE	190. INFORMANT'S NAME (Type/Print)		AlLING AODRESS (Street a	nd Number or Rural I	ST.		21204
	20a. METNOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE Of DISPOSITION (Name of Cappaign, crematory or other plage)						
	21. SIGNATURE OF EUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY 24. NAME AND ADDRESS OF FACILITY 25. NAME AND ADDRESS OF FACILITY 26. PUID						
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,							
	IMMEDIATE CAUSE (Final disease or condition	npications that caused the/death.		de of dying, auc	h aa cardiac or respi	ratory arrest,	Approximate interval Between Opaet and Death
	resulting in death) a	DUE TO (OR AS A CONSEQUEN	MCE OED:	2			2 weeks
TION	Sequentially list conditions, If any, leading to immediate b. ASPIRATION INCUMONITIS DUE TO (OR AS A CONSCOUENCE OF):						
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUEN	NCE OF):				
- 11	d	contribution to death but not any	10-1-11		I		
MEDICAL	PART II. Other significant conditions contributing to death but not reautifling in the underlying cause given in Part I. 246. WAS AN AUTOPSY PINDINGS AMALBLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 246. WAS AN AUTOPSY PINDINGS AMALBLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
. ME	VENICH EAULIPE					1 - YES 2 - NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one)						
IXSI	A TT MAD A PORTO	☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ □			6 Other (Specify)		
BY Pt	Netural 5 Pending 2 Accident Investigation	28e. OATE OF INJURY (Month, Day, Year)	ib. TIME OF 28c. INJURY WOL	JRY AT RK? ES 2 NO	28d. OEŞCRIBE NOW II	NJURY OCCURED	
	3 Sulcida 6 Could not be determined 28s. PLACE OF INJURY — At home, term, streat, tactory, office determined			281. LOCATION (Street and Mumber or Rural Route Number, City or Rown, State)			
OMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. MEDICAL EXAMINER: On the basis of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated.						
BE CO	29c. LICENSE NUMBER 29d. DATE SIGNED (Monthly Day, Year)						
0	Jasuen Valellani			D28595 1/22/99			
	ASNEEM (AKHANI, 7220 PARK HEIGHTS AVE BAEN MI)						
	31. DATE FILE PLES 1. Boy Young 1999	32. REGISTRAR'S SIGNATURE	1				21408



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Yaar Mary Cecelia Engelhardt Month January 29 1999 8:40 pm 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Tivan 144m 5. Social Sacurity Number If Undar 1 Yaar 7. Age (In yrs. last birthday) 8. Data of Birth Birthplaca (Stata or Foraign Country) 1 M 2 TF Months Days Hours Yrs. 217-05-6654 4/12/1899 Maryland Usual Rasidance of Decedant 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Timonium 1 Yes 2 No 10f. Zlp Coda 21093 10e. Street and Number 10g. Citizen of What Country? 2300 Dulaney Valley Road 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Detas: 1 □ Nevar Married 2 □ Merried 1 □ Yas 2 □ No Specify: White 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grade complated) Elamentary/Secondary (0-12) Collega (1-4or 5+) Tailor Seamstress 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Frances Schwartz Philip Griebel 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
2300 Dulaney Valley Road Timonium, Maryland 21093 19a. Informant's Name/Raiationship (Type, Print)
Mildred F. Bromwell 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burlet 2 □ Cramation 3 □ Removel from Stata 2/3/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 22. Nama and Addrass of Facility John C. Miller Inc. 21. Signatura of Sunt al Service License 6415 Belair Road Baltimore, Maryland 21206 Part1 Enter tha disaasa or s shock, or haart failure. List plications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, one cause on each line. Approximate tarval Bah Onsat end Death Immadiata Causa (Final PNEUMONIA disaasa or condition rasulting in daath) Dua to (or as a consaquance of): Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that Initiated evants rasulting in daath) Last Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? hesst EONS 5 1. 42 131/055 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical 26. Placa of Daath (Chack only ona) Othar: 4₺ Nursing Home 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 ☐ Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding Invastigation 1 Natural

/Medical Examiner law requires that the daath certificate be executed usa as tha buriel-transit and Box 68760, physician attending P.O.

ENGELHARDT,

VAME

Records,

of Vital

Division Attending

Examiner signed by t Director: Aftar thi

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daath.

To the Hospital of within 24 hours at To the Funeral D complately filled in

after a

Physician

/Medical

Examiner

10a Steta

MD

Director

by Funeral

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner traint be notified at

Pages 1 and 2 should be filled within nant of Haeith and Mental Hygiane. int: if item 27 is marked other than

nt of Hasith a: If item 27 is

permit. Page Department of Important: If any Injury or once.

Physician

filed within 72 hours after daath with the Marylend

21215-0020

Baltimore, Maryland

þ Completed Be 2

Physician/Medical

Certification: Medical

29a. Cartifiar (Check only one)

2 Accident

3 Suicida

4 T Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signatura and the of certifiar

6 Could not be datarmined

29c. Licansa number

1 ☐ Yas 2 ☐ No

D 15504

29d. Data signed (Month, Day, Year) 1.29 99

Timonium, Md 21093

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

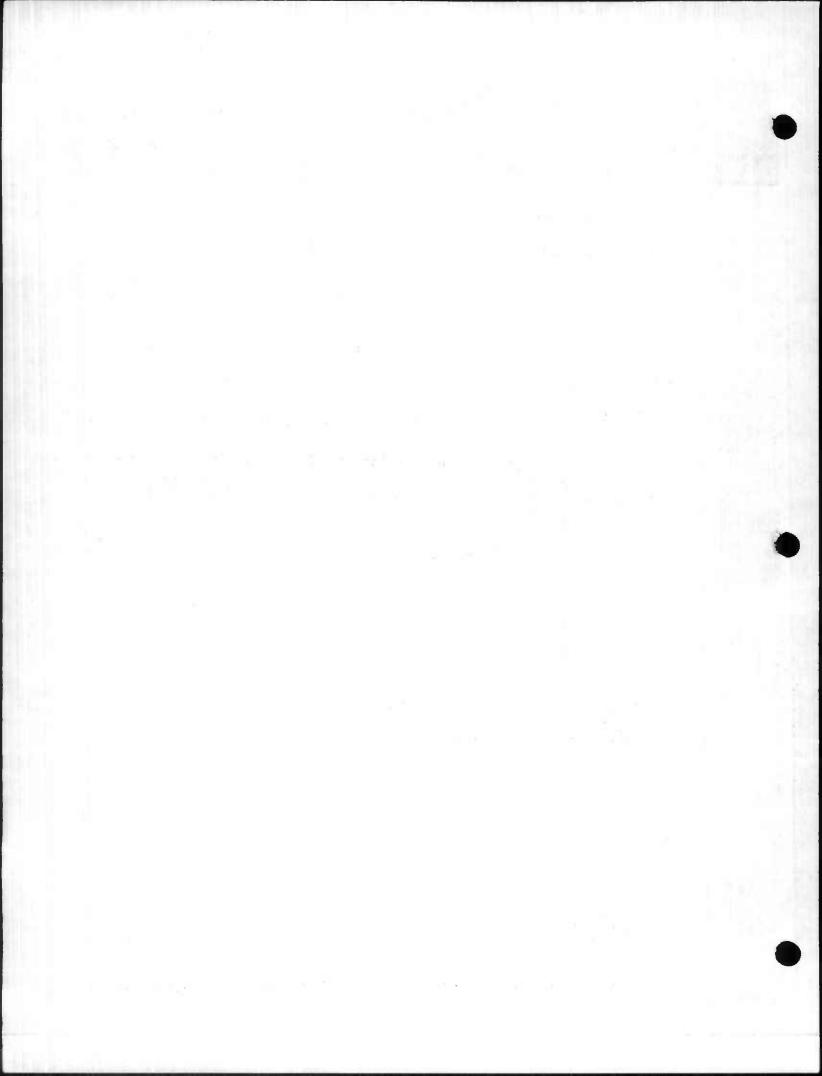
30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd

22. Ragistrar's Signatura

28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

State



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death **Physician** WILLIAM ALLEN ELLIS JANUARY 31 1999 2:06 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Nema (If not Institution, giva street and number) 4c. County of Death Examiner SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5 Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1QM 20F Months 216-16-8962 Yrs. 76 Director January 10,1923 Maryland Usual Residence of Decedant the Meryland 10d. Insida City Limits Pages 1 and 2 should be filed within 72 hours efter death with the Merylen nant of Health and Mentel Hyglene.

Interference 27 is marked other than "natural", or itsms 23s or 28s-f show any or other traumatic event, are Medical Example, must be notified at 10a Stata 10b. County 10c. City, Town or Location MD Baltimore 1 Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6440 Falkirk Road 21239 U.S.A. Funeral 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indian, 12. Was Dacedant Evar in U,S. Armed Forcas? 11. Maritel Status Black White atc I XYas 2 No f Yas, Giva 1 □ Nevar Married 2 □ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White à 3 □XWidowed 4 □ Divorced Yeer or Detes: Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banker Banking 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be Allen Ellis Carrie L. 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Robert Ellis 41 Thornhill Road Lutherville, Maryland 21093 20h Place of Disposition (Name of 20a. Mathod of Disposition Data 20c. Location - City or Town, State Immanuel Lutheran 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 2/4/99 Department of Important: If any injury or ance. Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Furnial Sarvica Licensaa 22. Nama and Addrass of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23e. Part. Enter the disaasa, or compositions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaen Onset end Deeth **Physician** /Medical Immediate Ceusa (Final A CARDIAC FAILURE DUE TO ISCHEMIA AND SEPSIS disaasa or conditio rasulting in death) 12 HOURS Examiner Due to (or as e consequence of): Examiner RESPIRATORY FAILURE DUE TO ADULT RESPIRATORY 2 WEEKS physician end the burief-transit requires that the death certificate be executed Sequantially list conditions, if eny, leading to immadiate causa. Enter Underlying Causa (Disaase or injury that initiated avants rasulting in daath) Last Due to (or as a consequenca of): DISTRESS SYNDROME, PNEUMONIA, PNEUMOTHORAX P.O. Box 68760 Physician/Medicai Dua to (or as a consequance of): CARDIOMYOPATHY AND SEPSIS 2 WEEKS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the causs of death? thed á Yss 2 No 3 Probably 4 Unknown STATUS POST CORONARY ARTERY BYPASS GRAFT bengis h Division of Vital Records. by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed been COMMUNITY ACQUIRED PNEUMONIA The lew hes le 2 certificate her 1 ☐ Yas 2 No 1 ☐ Yas 2 No director. or Attanding Physician: Be 25. Was casa refarred to medical 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA 70 this 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Deeth 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After 1 Naturel 2 Accidant 5 Panding 1 ☐ Yas 2 ☐ No death. thin 24 hours after death. the Funeral Director: Ampletely filled in by the fu invastigation 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Cartifiar ertifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and mennar as stated.

Control of the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the I and mannar stated 29d Day signed (Month, Day, Year) 29b. Signature and title of certiful 29c. Licansa number 0 D35453 ted cause of deeth (Item 23e) (Type, Print) LINDA BARR, M.D., 120 SISTER PIERRE DRIVE, TOWSON, MARYLAND 21204

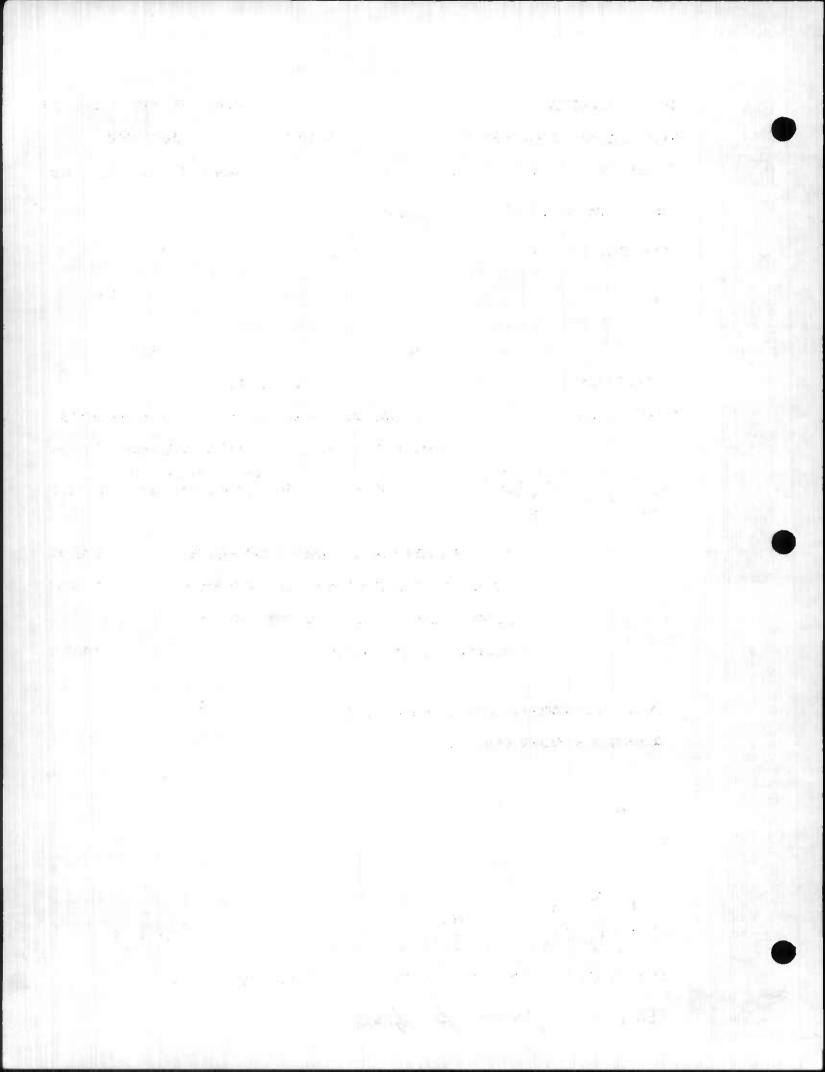
State Registrar

DHMH 16 Rav 6/95

31. Date filed (Month, Day, Year)

32. Ragistrar's Signatura

pach



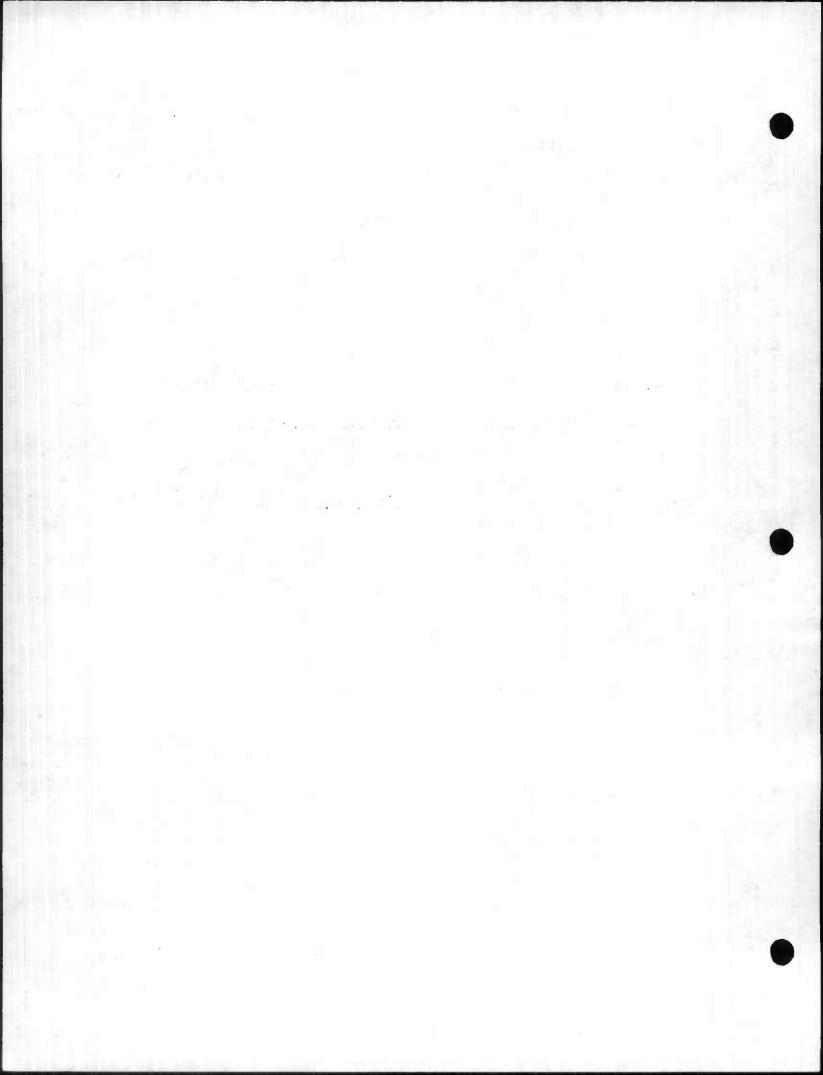
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dev **Physician** 3:00 P.M. 26, 1999 4c. County of Death Rose Sadie Florentine 4b. City, Town, or Location of Death /Medical 4a Facility Name (If not institution, give street end number) **Examiner** <u> 2843 Hinsdale Drive</u> Baltimore M Under 24 Hrs. 1 Birthplace (State or Foreign Country) If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□ M 20XF 95 Yrs. Director 1903 Maryland 217-48-7554 Usual Residence of Decede 10a. Stete 10c. City, Town or Location Od. Inaide City Limits 10b. County 28a-f show 1 X Yes 2 □ No Director Md. N/A Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b 2843 Hinsdale Drive U.S.A. 21230 Herns 23s Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yas, Give
Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: þ 3 0 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be liked within 72. Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natu any injury or other traumatic avera." 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Homemaker 8th 0 Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Paul Miceli Citrano Josephine 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) Gloria Gaskill (Daughter Maryland 21090 20c. Location - City or Town, Stete 6431 Orchard Road Linthicum, 20b. Place of Disposition (Name of cemetary, cremetory or other place) Date 20a. Method of Disposition 1X Buriel 2 Cremetion 3 Removel from Stete Cedar Hill Cemetery 1/29/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Emergal Service Licensee Kevin E. Ecker 22. Name end Address of Facility McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximete Interval Between Onset end Death **Physician** Immediate Cause (Fine) disease or condition rasulting in death) /Medical Examiner Examiner physician and the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Onknown 2 The law requires that Ven Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 2 No 1 ☐ Yes Division of Vital 25. Was case raferred to medical examiner?
1 ☐ Yea Be 26. Place of Death (Check only ope) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Certification: To 5 Presidence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funera After 5 Pending invastigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide edicai 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and mannar as etated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26307 1 news 30. Name end address of person who complated causa of death (Item 23a) (Type, Print) BALTIMOKE, MD21227 RD 4000 ANNAPOLIS RANIS. KARIPINENI 31. Date filed (Month, Day, Year). 32. Registrar'a Signatura State

DHMH 16 Rev 6/95

Registrar



Physician /Medical Examiner

physician and the burial-transit

3

signed be del

page 2

funeral director,

Completed

Be

10

Certification:

edicai

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

eftar death. Director: Aft

To the Hospital or Attervithin 24 hours eftar der To the Funeral Director complataly filled in by th

Depertment of important: If

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

10a State

Funeral

Director

orlant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinat, must be notified at

Pages 1 and 2 should be filed within 72 hours effer or not of Health end Mental Hygiene.
nt: If Item 27 is marked other than "natural", or Ner

Baltimore, Maryland 21215-0020

with the Maryland

deeth

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Physician/Medicai

Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.

chronic obstructive pulmonary disease

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

1 ☐ Yes 2 🗷 No 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident

28a. Date of Injury (Month, Dey Year)

28h Time of 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29e. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signatura and title of cartifier

29c. Licansa number

29d. Data signed (Month, Day, Year)

6 ☐ Could not be determined

RES-000

January

30. Neme and address of person who completed cause of death (Rem 23a) (Type, Print)

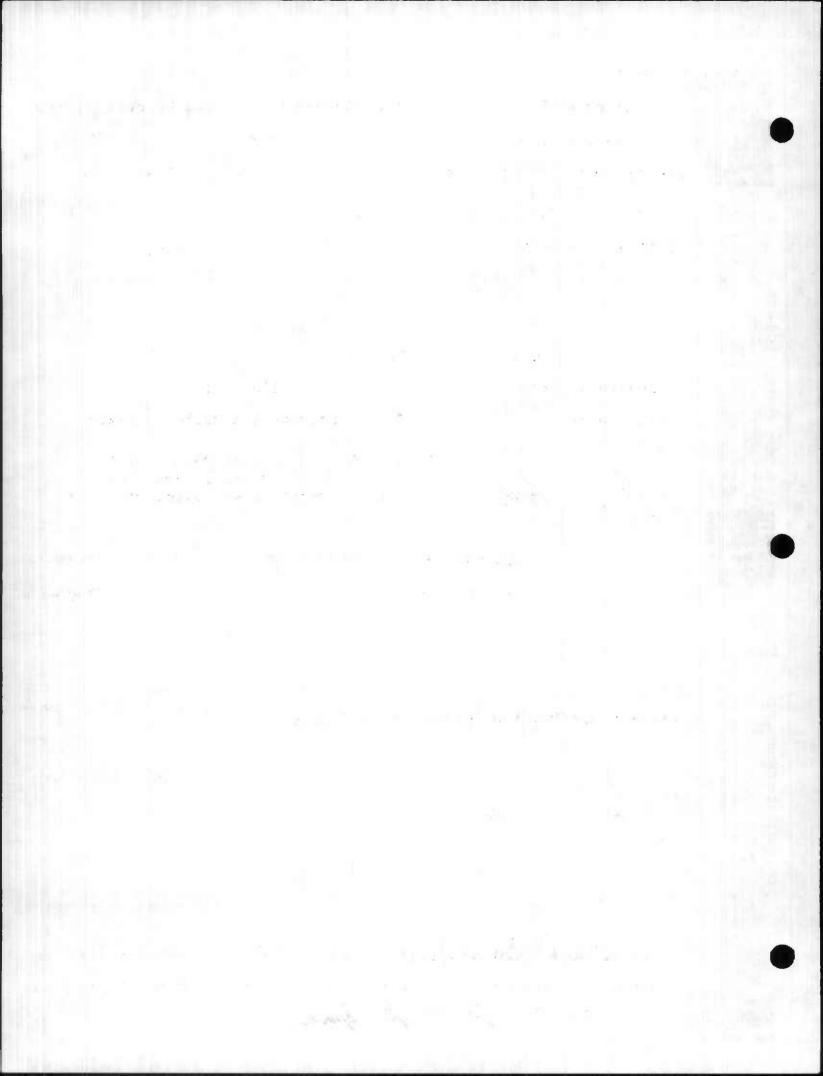
21205 Christine D. Bussey, M.D. 600 North Wolfe Street, Tower 110, Baltimore, Haryland

State Registrar 31. Date filed (Month, Day, Year)

FEB3

32. Registrar's Signeture

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Dav Yeer **Physician** 30 , 1999 4c. County of Death 1:30 AM BERTHA Μ. FERMAN JANUARY /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Genesis Hammonds Lane Nursing Center Brooklyn
If Under 24 Hrs. Park Anne Arundel Co. if Under 1 Year 5. Sociel Security Number 8. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) **Funeral** 1 M 2 X F Months Days Hours Min. Director SEPT. 30,1919 Maryland 218-09-4859 Usuel Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene.
Important: if itsm 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other treumatic avant, the Modeal Examiner must be notified an once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Anne Arundel Co. Glen Burnie 10g. Citizen of Whet Country? 10e. Street and Number Of, Zip Code U.S.A. 216 Wicklow 21061 Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritai Stetus Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: White py 3 Widowed 4 □ Divorced Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) P Harry Ferguson Mary Gerber 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Paul Zollickoffer (Nephew) 216 Wicklow Avenue, Glen Burnie, MD 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete Nation 2 ☐ Cremetion 3 ☐ Removal from Stete 2/2/99 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veternas Cemetery
22. Name and Address of Fecility Crownsville, Maryland 21. Signafüre of Funerel Service License 4107 Wilkens Avenue HUBBARD FUNERAL HOME nomas cianta () Baltimore, MD 21229 23a. Por the Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediete Cause (Finel disease or condition resulting In deeth) /Medical Shoke **Examiner** Due to (or as e consequence of): Examiner Hapmatin physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Vascular Box 68760 Dus tokor es e consequence of): Physician/Medical resulting In deeth) Last for use es 88 esn 23b. Did tobacco use contribute to the cause of death? ed by the deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 1 Yes 2 No 3 Probably 4 Unknown signed b p Division of Vital Records, 24b. Were eutopsy findings aveilable prior to completion of cause of death? been sig 24e. Wes an autopsy performed? Completed s certificate hes b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: director. Be 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Dete of Injury (Month, Dey Year) After thi funeral 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Certification: or Attending 1 Neturel 5 Pending 1 Yes 2 No thin 24 hours after death. othe Funeral Director: All ompletely filled in by the fu investigation after death. 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated. (Check only within 2. To the F one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 25654 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

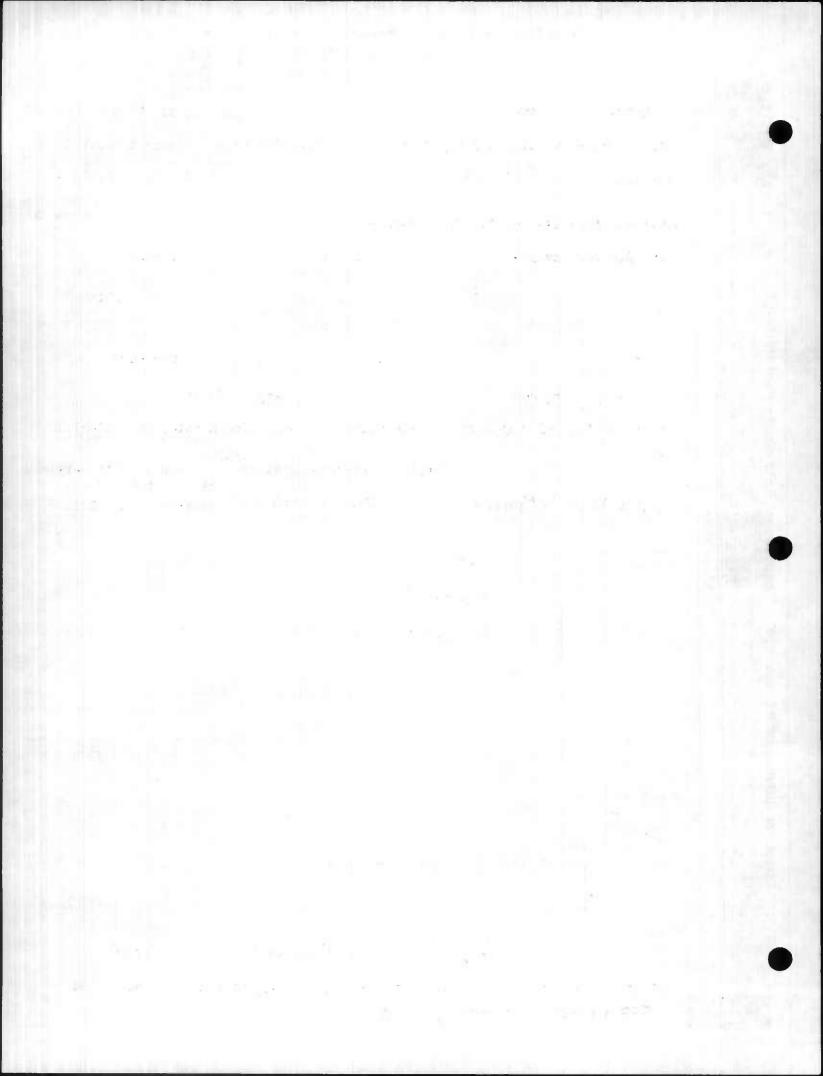
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State Registrar Date filed (Month, Dey, Year)
FEB 0 3 1999

Suite 6-A

A 1412 Crain Hwy., Glen Burnie, MD

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month GROSS KOBERT FEBRUARY 61, 1999 3.60 PM. /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death / 4c. County of Death Examiner BALTIHORE 7 SALTIHOKE (VITT HUNDER 1 VITT HUNDER 1 Year If Under 24 Hrs. Months Deys Hours Min. (Month, Day, Year) Country)

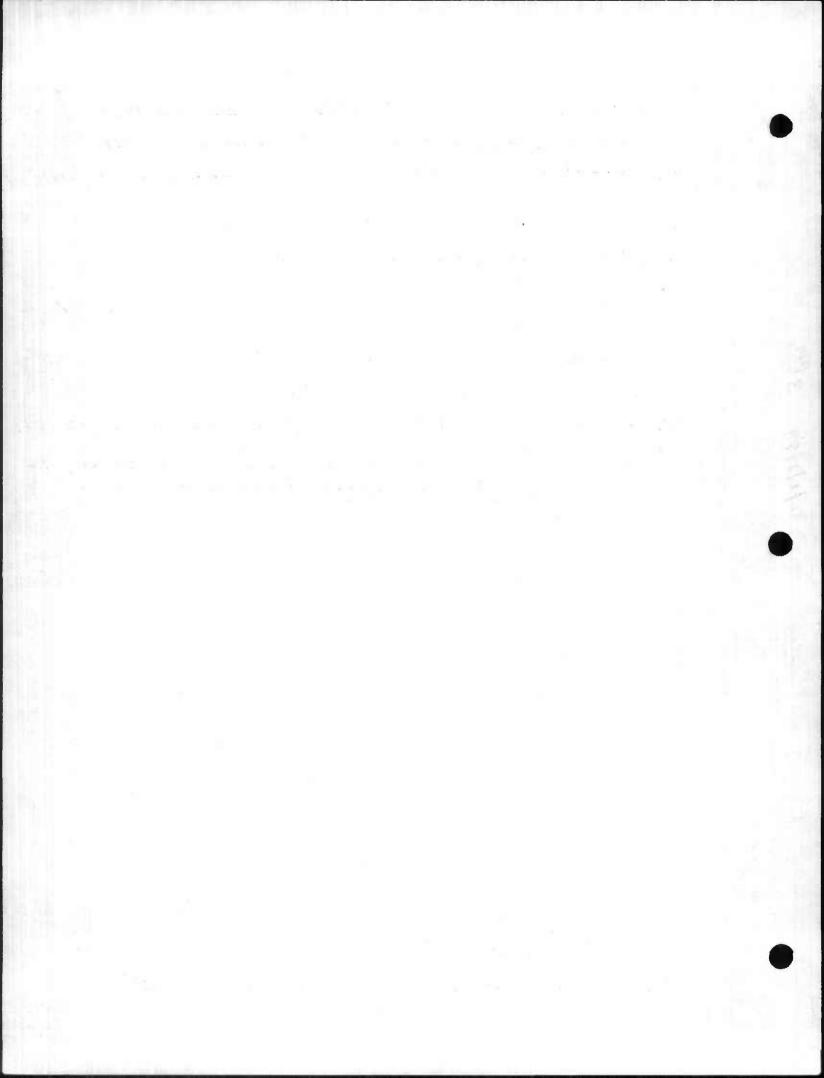
OCTOBER 07,1912 MARY LAWD APT, 20 EUTAW PLACE 5. Sociei Security Number 216 - 10 - 9093 7. Age (In yrs. lest birthday).

Yrs. 1 M 2□ F Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARYLAND 10e. Street end Number log. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examinar must be r 12. Wes Decedent Ever in U,S. Armed Forces? USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates: 1□ Yes 22 No Specify: BLACK Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) GRADE DRIVER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) of her mark to T is mark WILLIE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 701 EUTAW PLACE, APT. 216, BALTIMORE, MD. 21217 Department of Health Important: If them 27 is SADIE JOHNSON SISTER 20e. Method of Disposition

1. Burlei 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) ZION CEMETERY 02-05-99 LANSDOWNE, MD. 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME of Funerel Service Licensee 40 N. FULTON AVE. BALTIMORE, MD. 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or hear feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) 8 mos. Examiner attending physician and for use as the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Physician/Medical Due to (or as e consequence of): been signed by the a should be deteched Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Triknown à 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed this cartificate 1 Yes 2 TNo 1 Yes 2 No filled In by the funaral director, 25. Wes case reterred to medical examiner?

1 Yes 2 No Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Menner of Death 28e. Dete of fnjury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of Aftar Division 5 Pending investigation 1 Neturel death. 1 Yes 2 No 2 Accident after death 6 Could not be 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physictan: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) end menner stated. 29e. Certifier Medical (Check only one) 29b. Signature and title of certifes 29c. License number 29d. Dete signed (Month, Dey, Year) CATONSVILLE, Md 21228 31. Dete tiled (Month, Day, Year) 32. Regional 6 Signeture State Registrar

DHMH 16 Ray 6/95



State

within 2

sharman 31. Date filed (Month, Day, Year)

29b. Signature end title of certifier

(Check only one)

1999 FEB3

30. Name and address of person who completed cause

32. Registrar's Signature

of death (Ijem 23a) (Type, Print)

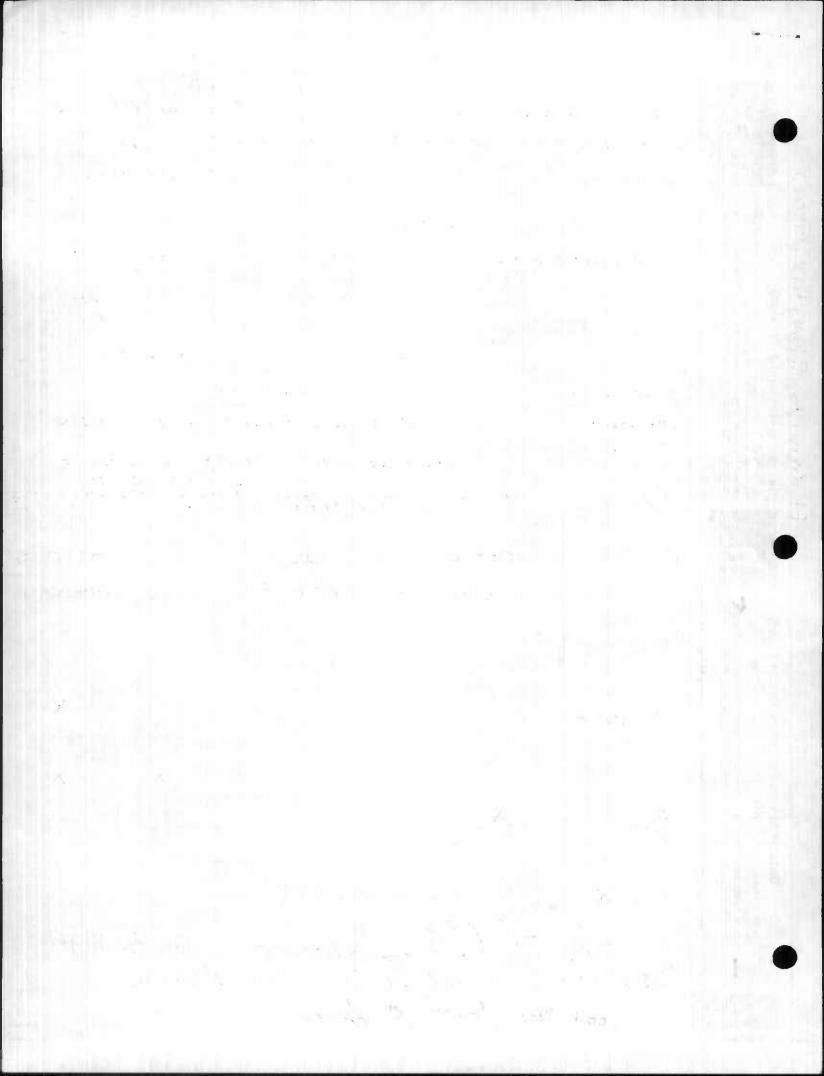
Boublook

29c. License number

RES-000

29d. Dete signed (Month, Day, Year)

Registrar



1. Decedent's Name (First, Middle, Last)

2609 DULANEY STREET

State of Maryland / Department of Health and Mental Hygiene

A CHAIR A MELINDER A VONE A FELINDER 24 Mrs. Co. D.

MTML	TEPD
-	

GEE

Certificate of Death

2. Dete of Deeth Month JANUARY 3. Time of Death 25, 1999

Physician /Medical Examiner

Winfield Gee 4a Facility Neme (If not institution, giva street and number)

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture

J. Laron Locke M.D.

31. Dete filed (Month, Day, Year)

4b. City, Town, or Location of Death

111 Penn Street, Baltimore, Maryland 21201

4c. County of Death Baltimore City

6:01P.M.

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hyglena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at 906e. Baltimore, Maryland 21215-0020

Physician /Medical Examiner

The law requires that the death certificate be executed signed by the e To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this cardifica completely filled in by the funeral director,

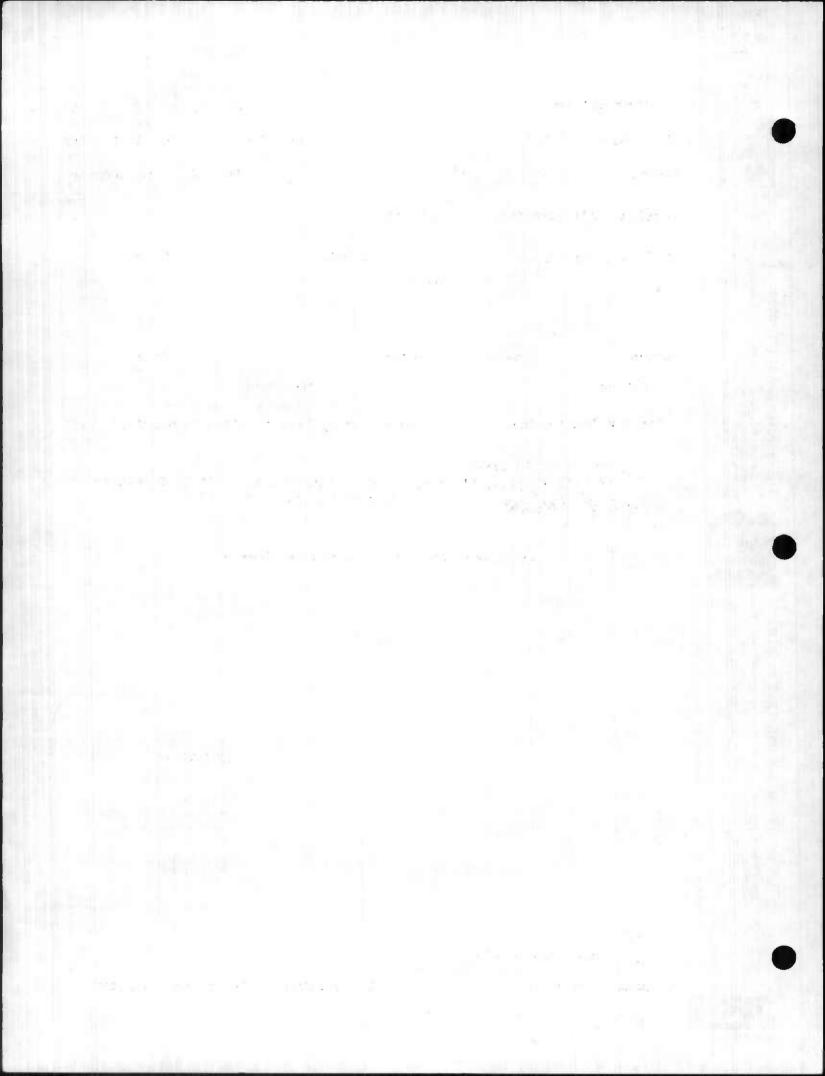
Division of Vital Records, P.O. Box 68760.

unknown	1 M 2□F 61	J. Mai Dillivay	lonths Days	Hours Min		, Year)	Country) unknown
Usuei Residence of Decedent 10a. Stete 10b. County Maryland Baltimo		City, Town or Locati Baltimore					10d. Inside City Limit
10e. Street and Number 2609 Duneley St			10f. Zip Code 21223			10g. Citizen of W	/het Country?
11. Marital Status 1 INVever Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? unl 1 Yes 2 No If Yes, Give Year or Detes:	_	s Decedent of as, specify Cub Yes 2 No		Specify Yes or No- to Rican, atc.)		e - American Indian, k, White, etc.
15. Decedent's E (Specify only highast gr	ade completed) Coilege (1-4or 5+)		d of work done NOT use retire	pation during most of wo d)	orking	16b. Kind of Bu	
unknown 17. Fether's Name (First, Middle, Las unknown	unknown	unknow	/II	18. Mother's Ne	ome (First, Middle,	unknow Maiden Sumam	
19e. Informent's Name/Reletionship Dorothy Perry/1					_{lurel Route Numbe} Baltimor		Stete, Zip Code) and 21223
20e. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Special	Removal from Stete	Pleca of Disposition cemetery, cremeter	on (Neme of ory or other pla	ce)	Date	20c. Location -	City or Town, Stata
21. Signature of Fundagi Service Lice 23a. P. Int. Enter the disease, ir con- shock, or heart failure. List only	Voce	Bal	timore	, Marylai	nd 21201		imore Street
disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	b Due to	(or as a consequer	nce of):	oral bis	sease		
Pert II. Other significant conditions	dcontributing to death but not re	esulting in the unde	rlying cause g	ven in Pert I.		obacco use cor ∕as 2□ No	ntributa to the cause of death
					INSPE		24b. Were autopsy findings aveilable prior to completion of cause of deeth?
25. Was casa referred to medical exeminer?	Hospital:		3□ DOA O	hor	eath (Check only o		1 Yes 2 No
1 Ness 2 No 27. Manner of Death 1 Naturel 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of		na 5X Residence 6 Other (Specify) 28d. Describe how Injury occurred			
3 ☐ Suicide 6 ☐ Could not I determined		home, farm, street	, factory, office		28f. Location (S City or Tov	Straet end Numb m, State)	er or Rural Route Number,
(Check only one) 2X Medical Exa	hysician: To the best of my kr minar: On tha basis of exemir end menner steted.	nowledge, deeth oc netion end/or inves	tigetion, in my	opinion, death occ	urred at the time,	dete and place,	and due to the cause(s)
29b. Signatup and title of certifler	belease			se number			26, 1999

Registrar

State

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Item: 19a per F.H G-768 2/3/99 reb 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev 2:30 P.M. 1999 Ruben L. Glasgow 30. 4b. City. Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth 5313 Fairlawn Avenue Baltimore N/A | Months | Deys | Hours | Min. | 8. Dete of Birth (Month, Dey, Year) | 11-11-1928 5. Social Security Number Sex WXM 2□ F 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country)
 V > Months 227-22-6992 Va 70 Yrs. Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a Stete 10h County 1 Yes 2 No Md N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 5313 Fairlawn Avenue 21215 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ÛNo If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Raca - American Indian 11. Menitel Stetus Bleck, White, etc. 1 ☐ Never Merried 2 🖾 Married 1 ☐ Yes 2XXNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Baltimore County Elementary/Secondery (0-12) 6th grade College (1-4or 5+) N/A Custodian Schools. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Samuel Glasgow Martha Miles 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Lottie Glasgow-Mother 5313 Fairlawn Avenue Baltimore, Md 21215 20e. Method of Disposition

X ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Pleca of Disposition (Neme of cemetery, cremetery or other plece) Dete 20c. Location - City or Town, Stete KING MEMORIAL PARK 2-4-99 RANDALLSTOWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility of Funerel Service Licansee March F/H West 4300 Wabash Avenue Baltimore, Md 21215 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth BREAST CANCER Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequenca of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 - Yee No 6 CANCER 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24e. Wes en eutopsy performed? TE CANCRA completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one, 1□ Yes PNo Hospital: Other: 4 Nursing Home ome Residenca 6 Other (Specify)
28d. Describe how Injury occurred 1 Inpatient 2 ER/Outpatlent 3 DOA 27. Manner of Deeth
Naturel
2 Accident 28c. Injury et Work? 28a. Dete of Injury (Month, Dey Year) 28h. Time of 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier (Check only one) Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

Medical Examiner: On the best of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and manner steted.

Division of Vital Records, P.O. Box 68760,

physician and s the buriel-transit The law requires that the death certificete be executed signed by the e certificate has b lirector, page 2 s Hospital or Attending Physician: 24 hours after death. director, After this funeral after death Director: in by n 24 hou. the Funeral Directory To the Hosp within 24 ho To the Fune completely fi

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Meniel Hygiens.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tra Mod call Examine must be not lifted at once.

Physician

/Medical

Examiner

Examiner

Physician/Medicai

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Certification:

Medical

29b. Signeture end title of certifier

30 Neme end eddress of person

31. Date tiled (Month, Dey, Year)
FEB 3 1990

who co

Baltimore, Maryland 21215-0020

State Registrar

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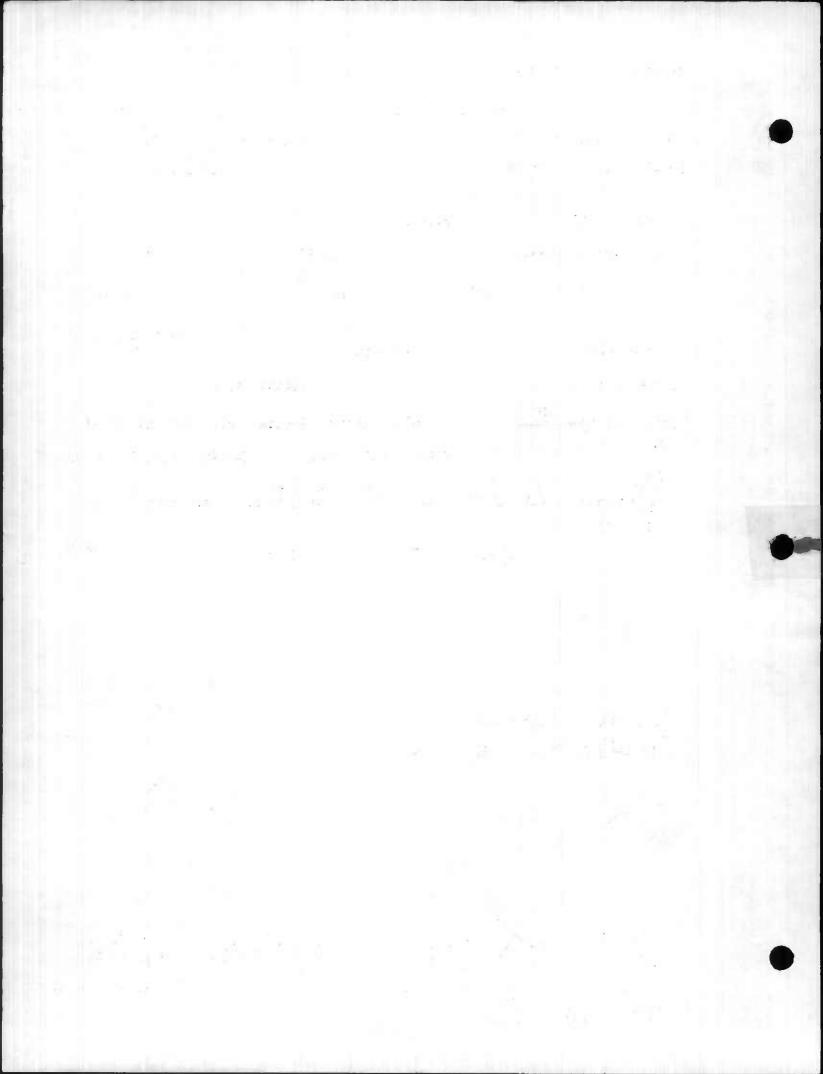
pleted cause of deeth (Item 23e) (Type, Print)

Registrer's Signeture

29d. Date signed (Month: Day, Year)

nss Mills MD 21117

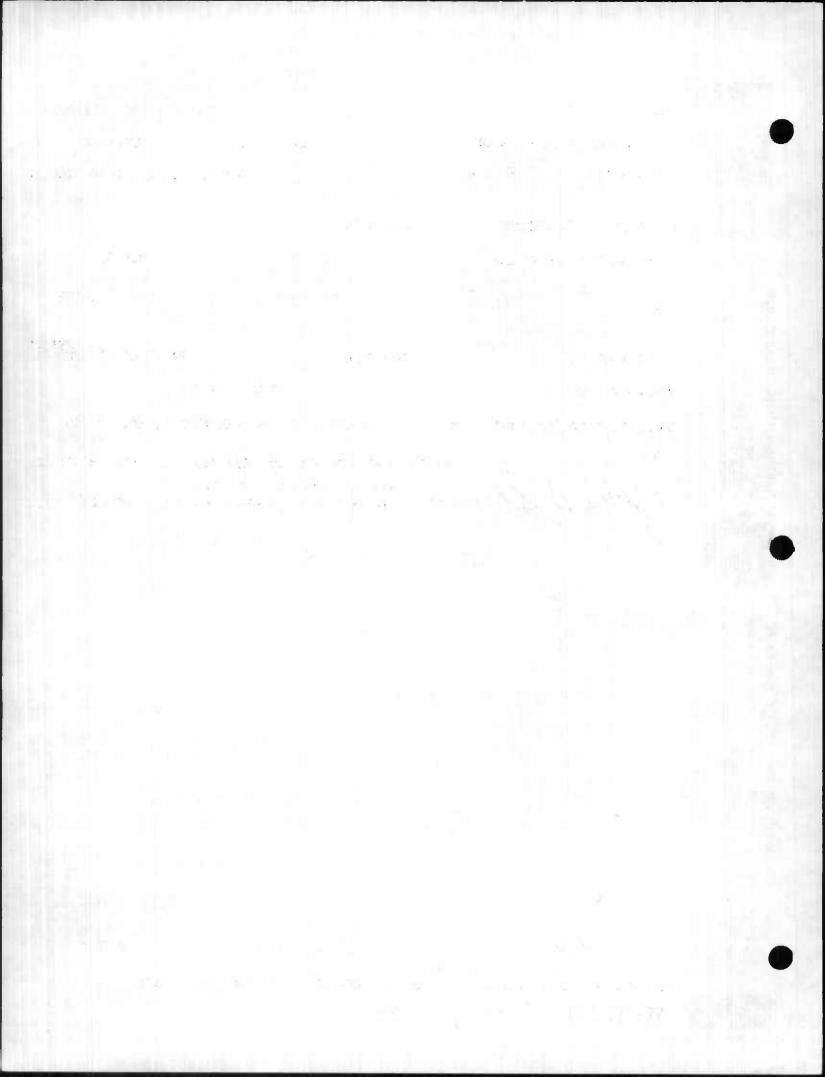
29c. License number



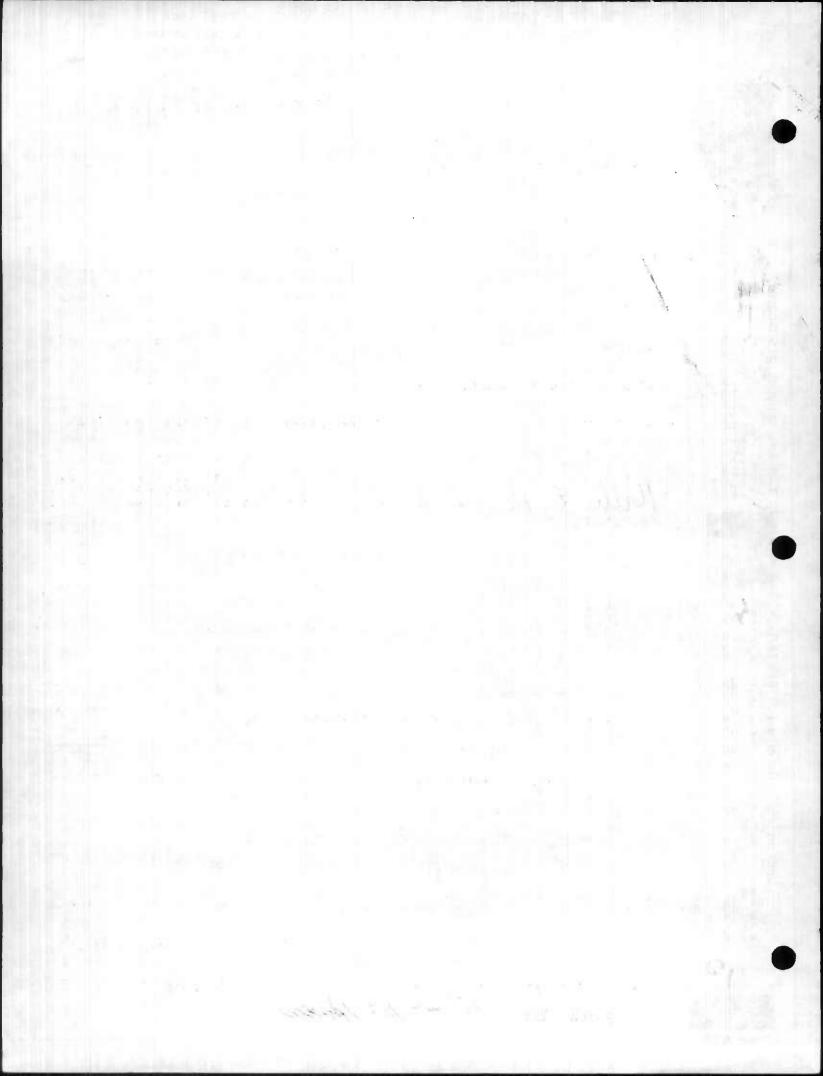
State of Maryland / Department of Health and Mental Hygiene 0 02708

						Cei	rtificate	e of	Death		R	eg. No.	U	2100
	Decedent's Name (First, Middle, Last)										2. Date of Death Month Day Yee			3. Time of Death
Physic /Med		RUTH H. GRI				JANUARY		27.1999 5:10						
Exam		4e Facility Neme (If not institt	ution, giv	e street and num	ber)				4b. City, To	wn, or Lo	cation of Death	4c. County		
		2409 HAMMOND	S FE	RRY ROA	D				LANS	DOWN	E	BAL	TIMO	RE
Funera Director		5. Social Security Number 215–16–9797	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.											
yland		Usual Residence of Deceden 10a. State 10b. Cou	_		10c. City, 3	Town or Lo	cation							10d. Inside City Limi
the Mar 28a-f si	Director	MARYLAND BALTIMORE LANSDOWNE 10e. Street and Number 10f. Zip Code									1 ☐ Yes			
A S	0	O/OO HANDIOND		DAY DOAD				2	1227			11	S.A.	
deeth	era	2409 HAMMONDS	5 rei	12. Wes Deced	dent Ever in U.S.	13.1	Was Deced			igin? (Spe	ecify Yes or No-		e - Ameri	can Indian,
within 72 hours after deeth with the Manyland ene. than "natural", or itema 23a or 28a-f show item devices Examiner must be now and	by Funeral	1 Never Married 2 Never Marrie		1 ☐ Yes 2 If Yes, Give	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispenic Origin? (S If Yas, specify Cuban, Mexican, Puert □ Yes 2□XNo Specify:				to Rican, etc.) B		lack, White, etc. bity: WHITE	
d within 72 hours af jiene. r than "natural", or	Completed	15. Dece (Specify only hi	dent's Ed ghest gra	ducation ide completed)		(Give	iant's Usua kind of wor DO NOT us	rk done	e during mos	t of worki	ing	16b. Kind of Bi	usiness/ir	ndustry
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should and Men marke	2	NORMAN WHITM									N DUBREA			
2 9 8 8		19a. informant's Name/Relat	ionship (Type, Print)							al Route Numbe			
ges 1 and to 1 le le le le le le le le le le le le le		SUSAN E. ILE	Y (GI	RANDDAUG					AVENU	E - (GLEN BUR			21060
F Her Her or oth		20a. Method of Disposition 1 ♀ Burial 2 ☐ Cremati	on 3 🗆	Removal from S	cem	ea of Dispo letery, crar	sition (Nan matory or o	na of ther pl	ace)		Date	20c. Location -	City or T	own, State
permit. Pages 1 as Department of Heal moortant: If them in y injury or other size.		4 Donation 5 Othe				DOWRI	DGE M	EMO	RIAL :	PK 1	1/29/99	ELKRII	OGE,	MARYLAND
permit. Par Department Important: any injury		21. Signature of Funeral Sen	rice Lice	isee //		22	. Name an	d Add	ress of Facili	ity	E, INC.			
Physician /Medical	Ī	23a. Parry. Enter the disease shock, or heart failure.	e, or com List only			Do not ent	er the mod	a of dy	ring, such as	ENUE cardiac	-BALTIM or raspiratory an	ORE, MA	RYLA	Approximata interval Batween Onset and Death
Examiner	и.	disease or condition rasulting in daath)		e	BRe25	T	CAM	CE	12					3 YRS,
	-				Dua to (or a	s a consac	quance of):						1	,
pe is	line			b									1	
infficete be executed ing physicien and as the buriel-transit	I Examiner	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events	J		Due to (or as a consequence of):									
artificate be exing physicien as the buriel	Medical	that initiated events resulting in death) Last	J		Due to (or e	s a conseq	uence of):							
eath cert attendin	lan			O										
ires that the death or signed by the attend do be detached for us	Physician/	Part II. Other significant con-	ditions c	ontributing to dea	ath but not resulti	ng in the u	nderlying c	ausa g	iven in Part	ŧ.	23b. Did to			to the cause of deat obably 4 □ Unkno
gned t	by P												T	
been shoul	Completed										24a. Was a perfor	an autopsy med?	a	Vere autopsy finding vailabla prior to ompletion of cause f daath?
The law ete has page 2	E OC										1 🗆 Y	es 2000	1	☐ Yes 2☐ No
vicien: The	Be	25. Was case referred to me	dical						26. Plac	e of Death	h (Check only o	ne)		
Physician: This certific	10	examiner?		Hospital:	patient 2 EF	VOutpetier	nt 3 DC	DA C	ther: 4 N	ursing Ho	me 5 Resid	anca 6 □Oth	ner (Spec	ify)
			1 Natural 5 □ Pending		28e. Date of Injury 28b. Time of Injury at Work?				28d. Describe how injury occurred					
al or Attending R s efter death. if Director: After ad in by the funer	Certification:		uld not be termined	288. Piece	of Injury - At hom g, atc. (Specify)	e, farm, str	reet, factory	y, office	Э		28f. Location (S City or Tow	treet and Numi n, State)	ber or Ru	ral Route Number,
To the Hospital within 24 hours To the Funeral completely filled	edical (pest of my knowle sis of examination or stated.									
thin the	New Year	29b. Signature and title of cer	titier	and main	o. statou.	-	290	c. Lice	nse number			29d. Dale signe	ed (Month	, Day, Year)
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		30. Name end address of per												
		DR. KENNETH	H. V	VILLIAMS	- 1120	N. R	OLLIN	G R	OAD -	CATO	NSVILLE	, MARYI	LAND	21228
Si	ate	31. Date filed (Month, Day, Y.		/ 32. Re	glstrer's Signatur									
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	4 December to Ma	(Flank & Ald at	(no.4)	Death	Reg. No.								
ysician fedical	1. Decedent's Name (First, Middle, Last) HATTHEW						HASKINS Det 1999 3. Time of Death Month Dey Year 11:25 A						
aminer	4a Facility Name (If SINAI		give street and nu $ITAL \ OF$		IMORE	100	4b. City, Town, or BALTII		h" 4c. County	of Deeth	•		
eral ctor	5. Sociel Sacurity Nu 217-18-		. Sex 12 M 2 F	7. Age (In yrs.	last birthday) 5 Yrs.	If Under 1 Yaar Months Days	if Under 24 Hrs		th (1923		(Stete or Foreign		
	Usuai Residence of I	Decedent 10b. County		T100 Ci	ty, Town or Loc	ation				104	Incide City Limits		
rai Director	MD	N /	A		ALTIMO					100.	Inside City Limits 1 ☑ Yas 2 ☐ No		
Director	10e. Street and Num	ber		10f. Zip Coda 10g. Citizen of Wh							?		
	4554	The St	rand	and 21215					U	U.S.A.			
by Funeral	11. Maritai Status 1 Never Merria 3 Widowed 4		Armed Fo	2 No	If Yes, specify Cuban, Mexican, Puàrto Rican, atc.) 1 ☐ Yes 2 ☑ No Specify: Specify:						- Amarican Indian, k, White, etc. Black		
Completed	(Specil	15. Decedent's by only highest	Education grade completed)		16e. Decede	ent's Usuai Occu ind of work done	pation during most of wo	rking	16b. Kind of Bu	usiness/Indus	try		
- mp	Elementery/Secon		College (ONOTuse retin GShorei			Steams	hip T	rade		
Be Co	17. Father's Name (F		st)			, , , , , , , , , , , , , , , , , , , ,		me (First, Middle	, Meiden Surnan	10)			
To B	Matthe	w Samu	iel Has	kins,	Sr.		Ole	nia Chi	ristian				
	19a. Intormant's Na						t end Number or R						
	Gloria 20a. Method of Dispo		15	20h	455		Strand,	Baltin	20c. Location -				
		Cremation 3	☐Removal trom	State	cemetery, crem	etory or other pla	st Vet.		Owings				
	21. Signature of Fun 21. Signature of Fun 223a. Part1. Enter the shock, or heart	arai Sarvice Lic	ensea Hou	rell	Mac 4	600 LI.	DYETT	& SON EIGHTS	AVE., B	L HOM			
Examiner Examiner	Immediate Cause (F disease or condition resulting in death)		a			HONI	FAIU	ur			5 PAYS		
edicai	Sequentially list con if any, leading to imit ceuse. Enter Undar Cause (Disease or In that initiated events resulting in death) La		c		1100 1110	ano JA	SCULAR	PISE	SASE)	YCAR		
Physician/M	Part II. Other eignific	cant conditions	contributing to d	eath but not res	sulting in the un	dariving ceusa g	iven in Part I.	23b. Did	tobacco use co	ntribute to th	e cause of death?		
by Phys								ISE 10	1 Yes 2 No 3 Probably 4 Unknow				
pleted							GILAR DISE	24a. Was perf	24a. Was an autopsy performed?		autopsy tindings ble prior to lation of causa ath?		
Con		SEE	ne 17	GART	FAIG	UNB		10	Yas 2 No	1 🗆 Y	es 2000		
Be Be	25. Wes cese reterre examiner?	ed to medical	Hoepital:	,		0	ther.	eth (Check only					
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Certification:	1 Neturel 2 Accident 3 Suicide 4 Homicide	5 Pending investigat 6 Could not determine	ion be 28e. Piace	28e. Dete of Injury (Month, Day Year) 28b. Time of Injury at Work? M 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, tarm, street, factory, office					28t. Location (Street and Number or Rurel Route Number, City or Town, Stete)				
Completely filled in by the Medical Certificat	(Check only one)	Medical Ex	aminer: On the b and man	asis ot exa <i>m</i> ine ner stated.	etion end/or inve	estigation, in my	ime, date and place opinion, deeth occi	urred et the time,	date and place,	and due to th	e cause(s)		
W	29b. Signatura and t	itle of certifier	ly 1	110.		29c. Licer	29c. License number D 22609 SANVARY 31-199 Int) FURNACE BRANCH Rd GIEN BURNE MA 9. Associth						

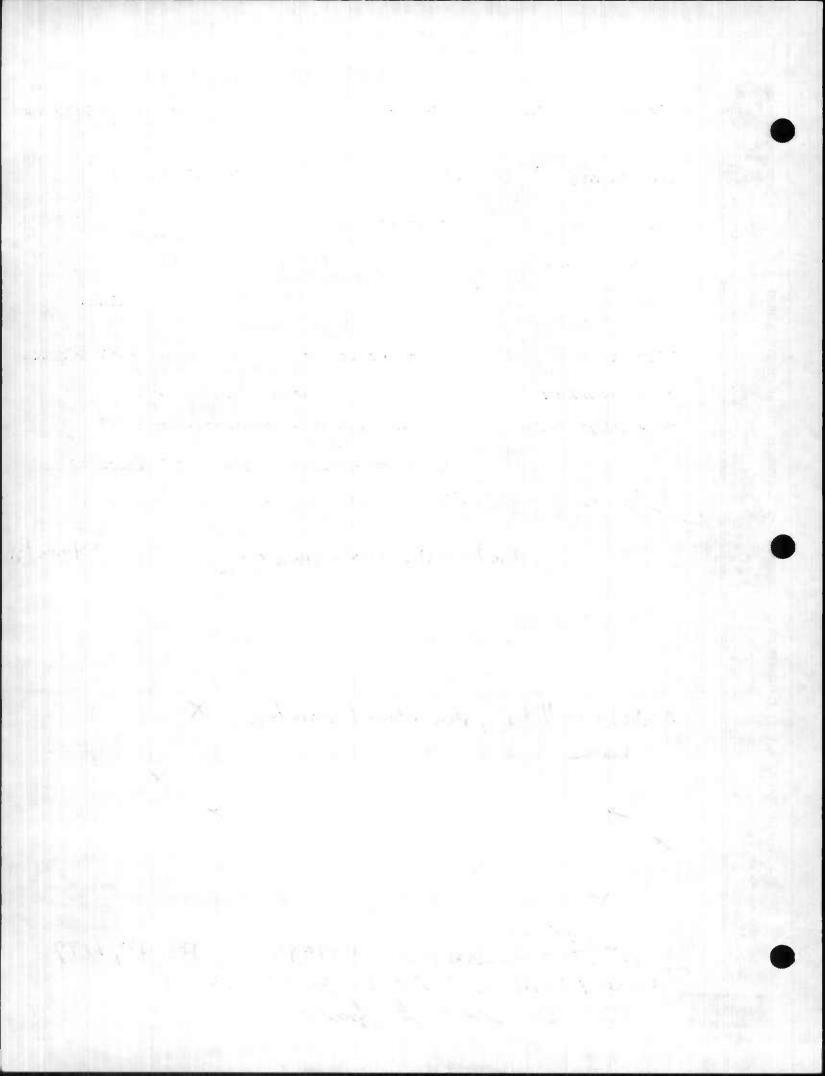


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Mogth Yeer **Physician** Steve 1999 Harper 3:13 pm /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner 005 Glen Baltimore thenue If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number Birthpiace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months 10XM 20 F Yrs. Director 56 06 05 AL 220-38-6014 Usuel Residence of Decedent r 28a-f show a notified at 10s. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Itama 23a or edical Examiner must be r Funeral U.S.A. 14. Rece - American Indian, 4005 Glen Ave 21215 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours effer 1 ☐ Never Married 2 ☑ Married 1□ Yes 2□ No Baltimore, Maryland 21215-0020 Specify: Specify: Black λq 3 ☐ Widowed 4 ☐ Divorced Hygiene. other then "nature ent. the Medical E Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementery/Secondery (0-12) College (1-4or 5+) 12th grade Truck Driver Cooks Fuel Service permit. Pages 1 and 2 should be filed.
Disparant if them 27 is meany injury or other. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be James Tolliver Fannie Mae Gilbert 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Harper-Wife 4005 Glen Ave, Baltimore, Md 21215 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition WDBuriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 Donetion 5 Other (Specify) Baltimore Cemetery 2/6/99 Baltimore Md 22. Name end Address of Fecility 21. Signeture of Funerel Service Licenses 21215 1300 Dalto, mil Wabash grenue Part Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final 44 mon disease or condition resulting in death) Due to (or es e consequence ot): Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician i the burial Division of Vital Records, P.O. Box 68760 certificate be Physician/Medical Due to (or as e consequence of): 10 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 2 1 Yee 2 No 3 Probably 4 Unknown horsigned to þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? disease reatificate has frector, page 2 r 1 Yes 2 No 1 TYes 2 TNo 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) 1 Yes 200 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 名 28e. Dete of Injury (Month, Dey Yeer) 27. Manner of Death 28b Time of 28c. injury et Work? 28d. Describe how injury occurred Natural Accident Attending 5 Pending 1 Yes 2 No death. investigation after desti Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 C Homicide b Funeral C Hospital 24 hours a Medical Examiner: On the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) end menner stated. Medical 29a. Certifier (Check only one) To the To the 29b. Signature and title of cedile 29c. License number 29d. Dete signed (Month, Day, Year) mys 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 3333 Yshorie WAI 31. Dete filed (Month, Dey, Year) 32. Registral's Signature State FEB 3 1999

DHMH 16 Rev 6/95

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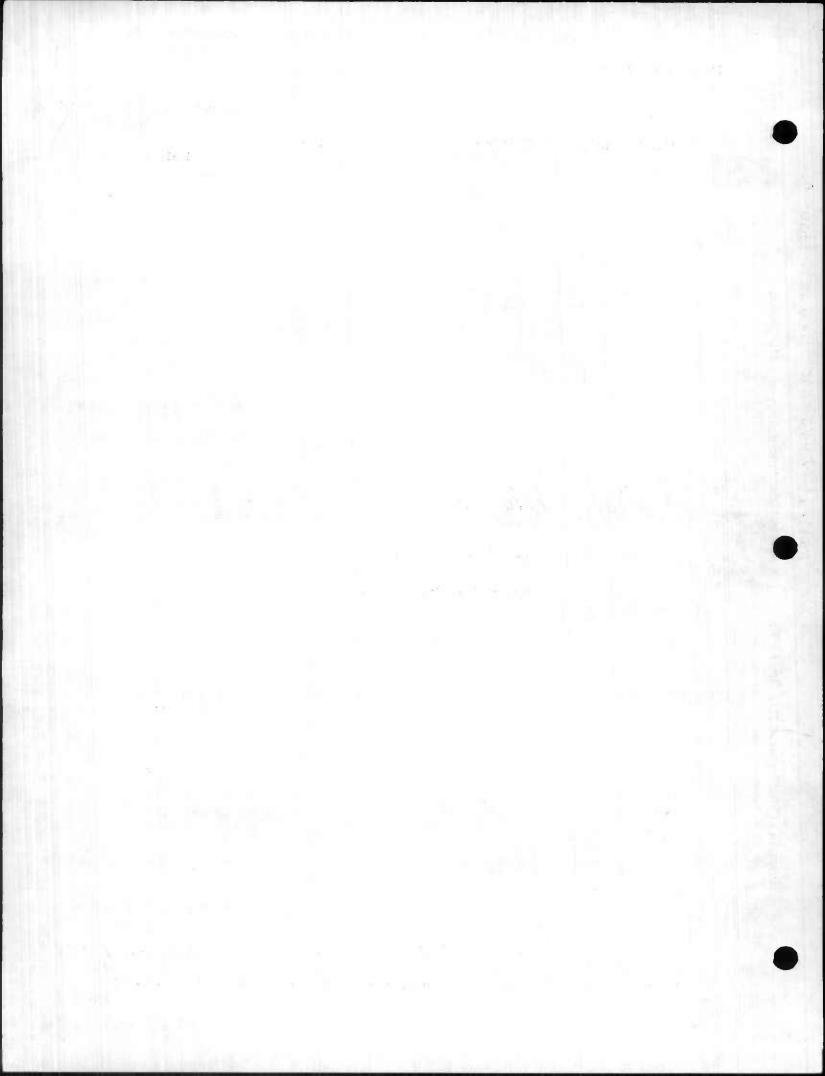
24 hours

within 2

Item#8 perFH G768 2/4/98 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1, 1999 House 4:26 pm Debovah February /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 50 Yrs. 6. Sex 8. Date of Birth1-31-49 (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 YF Days 216-50-0776 Director Md Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f ahow traumatic evant, the Wed cal Examiner must be notified at 1 ☐ Yas 2 ☐ No Director Baltimore Md N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5252 St Charles Avenue Funeral 21215 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working) Human Resources Coordinator Proctor & Gamble Elementery/Secondery (0-12) 12th grade nd Mental Hygiene. Cotlege (1-4or 5+) N/A 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Pages 1 and 2 should be familiar the first of the first and the first and the first and the first and the first and Gladys Bristow Adia House 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numbar, City or Town, Stata, Zip Code) 38 Lower Court Owings Mills, Md 21117 Department of Heelth Important: If Itsm 27 Charles Fallin- Son 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery 2-6-99 Baltimore, Md 22. Name and Address of Facility
March F/H Wes 21. Signature of Funeral Service Licensee West 4300 Wabash Avenue Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate fntervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Medical . Cardiogenic Shock aminer Due to (or as a consequence of): Examiner Myocardial Infarction the attending physician and hed for use es the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequenca of): Physician/Medical Due to (or as a consequenca of) datached for use es 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 8 24b. Wera autopsy tindings eveilable prior to completion of causa of death? 24e. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical exerciner? Be 26. Place of Death (Check only one) exeminer? 14☑ Yes 2☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 11☑Inpatient 2☐ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ONatural 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Year) meno 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Sinai Hospital of Baltimore 2401 W. Belvedere Alejandro Sequeira, MD 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State Registrar 1999 **DHMH 16 Rev 6/95**

Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month February 1, 1999 9:55 AM Jemima Ellen Hambruch 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore Baltimore 7 Gamewell Garth If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. lest birthday) Months Deys 1 M 2 X F Yrs. 69 December 21, 1929 Pennsylvania 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 21XNo Baltimore **Baltimore** 10f. Zip Code 10g. Citizen of What Country? 21236 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Giant Food Collaga (1-4or 5+) Pharmacy

5. Social Security Number **Funeral** 217-24-6489 Director Usual Residence of Decedant the Maryland permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Haalth and Mental Hygiana. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be northly at an 10a State Director Maryland 10e. Street and Number 7 Gamewell Garth Funeral 11 Maritel Stetus 1 Never Married 2 Married à 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Technician 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Margaret Fraizer Robert Donald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21236 Linda Topolski / Daughter 7 Gamewell Garth 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 2-5-99 Parkville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Timothy Harman Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road **Physician**

/Medical Examiner

Physician

/Medical

Examiner

physician and the burial-transit signed by the a ρ Completed director, Be this

The law requires that the death certificate be axecuted s cartificata has t director, paga 2 s Certification: To Aftar this

Division of Vital Records, P.O. Box 68760, or Attending Physician: daath. Director: A

in 24 hour.
The Funeral Direction of the filled in To the Fune To the within 2 To the

Registrar

edical

Balto., MD 21214 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onset and Death Immedieta Ceuse (Finel disease or condition resulting in death) METASTATIC CAMCER Dua to (or as a consequence of) Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE LONG DISTAIL

24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy performed?

2 DNO

1 ☐ Yes 2☐ No

26. Place of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Certifying Physician: To tha best of my knowledga, daath occurred et the tima, data and plece, end due to the cause(s) and manner as stated.

29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

IM

47945

February 02 1999 21214

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

300). E. Northern Parkway Balhmore MD Haris

31. Date filed (Month, Dey, Year) FEB Q 3 1999

PAN CYTO PAENIA

5 Panding

Investigation

6 Could not be datarmined

25. Was casa rafarrad to medical examiner?

1 Yas 2 No

27. Manner of Death

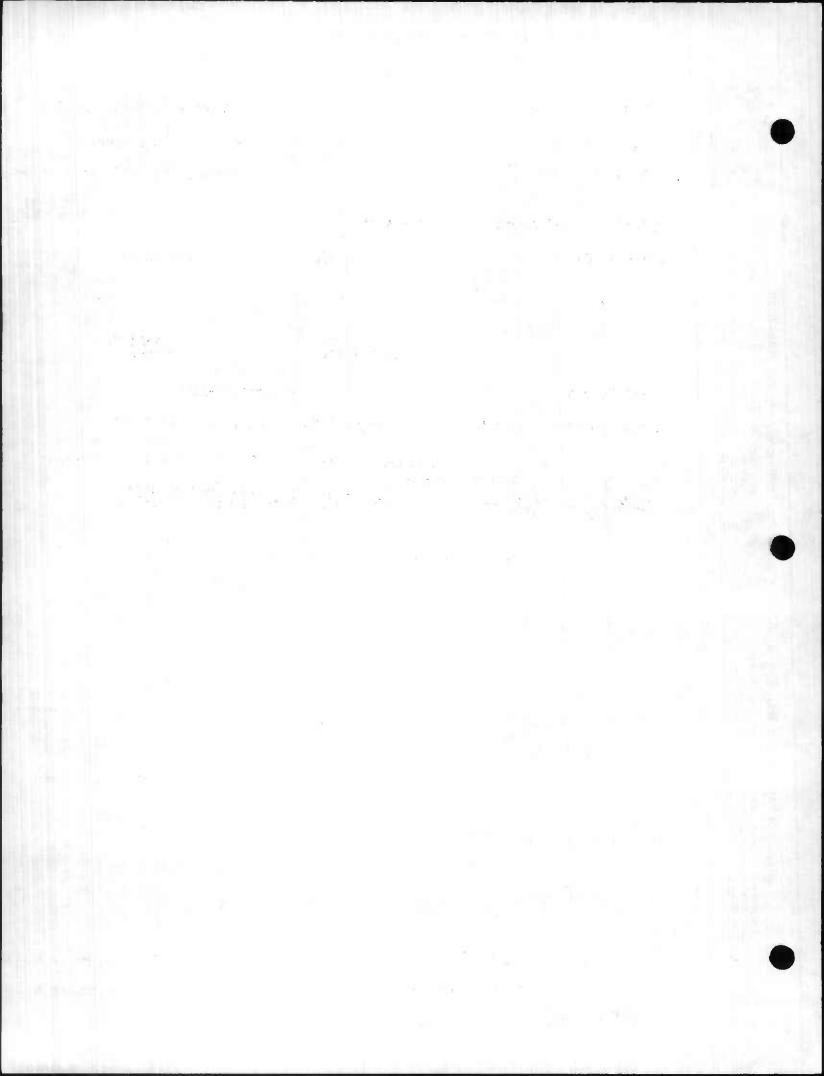
1 Natural

2 Accident

4 Homicide

3 ☐ Sulcida

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** January 31, 1999 Teresa Gertrude 1:00 a.m. Herbert /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Samaritan Nursing Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2□F Director 217-09-3045 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. foside City Limits 1 Yes 2 □ No Director 28a-f Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò Barras 23a E. Belvedere 1601 21239 U.S.A. Ave Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No Specify: altimore, Maryland 21215-0020 Specify: À White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employeed 8th. Grade Hair Dresser 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 89 Pages 1 and 2 should be named of Health and Mental unt: If flow 27 is marked of John Merzbacher Anna Berg 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) mportant: If Item 27 any injury or other tr Ann Langkam/ Daughter 3508_ Glenwood Road Baltimore MD 21220 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 Daurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 21/2/1999 Baltimore MD 21. Signature of Funeral Survice Licensee 22. Name and Address of Facility John C. Miller, Inc. 6415 Belair Road Baltimore 23e. Part F. Entail Unit of Gase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cadse on each line. Approximate tritervat Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner ician and burial-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Box 68760 Physiclan/Medical Due to (or as a consequence of) P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings aveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After or Attanding 5 Pending n 24 hours after death.

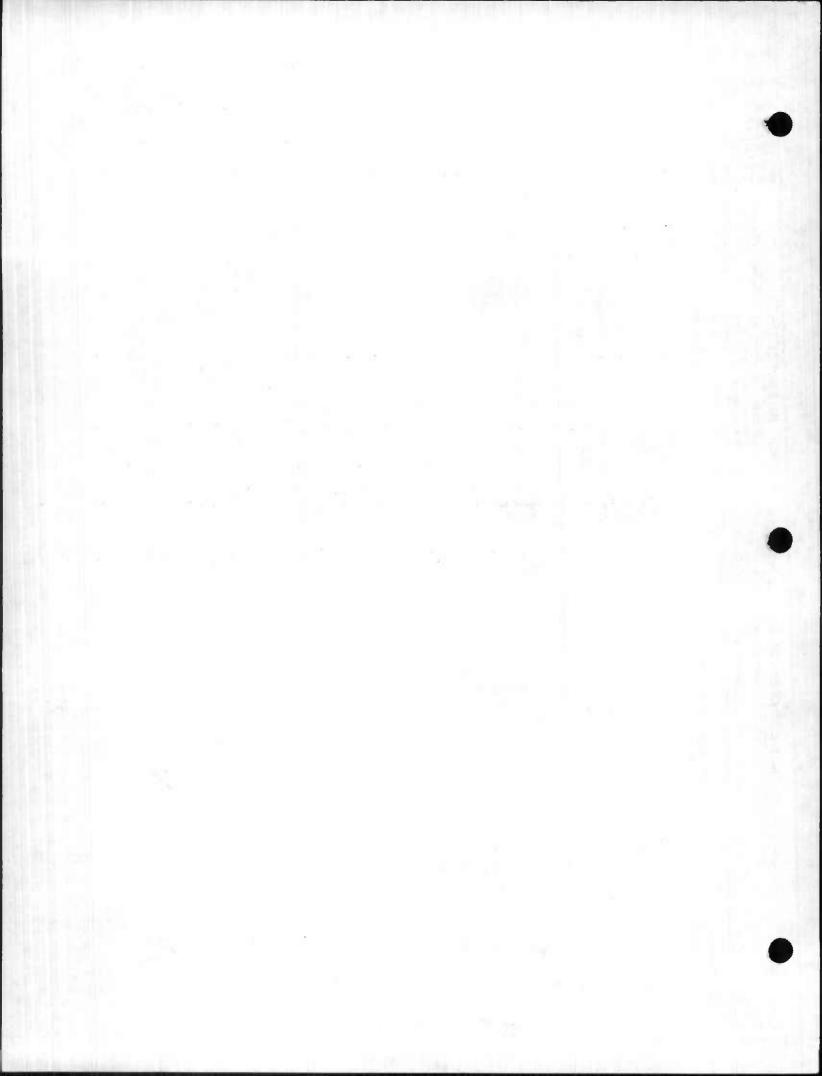
Ne Funeral Director: All pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of conflien 29c. License number
D25391 29d. Date signed (Month, Dey, Year)

2-1-99 5601-Loch Raver Blvd, Bulto, 21239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammed 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

Registrar

FEB 3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Veer VERNON MILTON HANIXMAN 25, 1999 JANUARY 12:57 AM 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death ARUNDEL GLEN BURNIE 342 THELMA AVENUE f Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex. 1 → M 2 ☐ F Birthplace (State or Foreign Country) Months Days 78 215-12-1024 NOV 20,1920 MARYLAND Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d Inside City Limits 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 342 THELMA AVENUE 21061 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 No WW II Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 N Merried 1 Yes 2 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Induatry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 8TH GRADE MACHINIST 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) ALBERT HANIXMAN EDNA VANSKIVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH H. HANIXMAN(WIFE) 342 THELMA AVENUE - GLEN BURNIE, MARYLAND 21061 20a. Method of Disposition 20b. Piece of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) MEADOWRIDGE MEMORIAL PARK 1/28/99 ELKRIDGE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 any Sor 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 46 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? YPENTENS FOR ugn+ left SISS D STNOKE 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 Neturai 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 🖶 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner as stated. (Check only one)

that the death certificete be executed Division of Vital Records, P.O. Box 68760, The law requires al or Attending Physician: The safter death.

Il Director: After this certificated in by the funeral director, pe within 24 hours aft To the Funeral Di completaly filled in Hospital

Physician

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Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Nems 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified an ence.

Physician /Medical

Examiner

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Certification:

Medical

State Registrar

31. Date tiled (Month, Day, Year) FEB 0 3 1999

29b. Signature and title of cadific



30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

and menner stated.

DR. DAVID ROSE - 200 HOSPITAL DRIVE - SUITE 500 - GLEN BURNIE, MD 21061

MND

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(a)

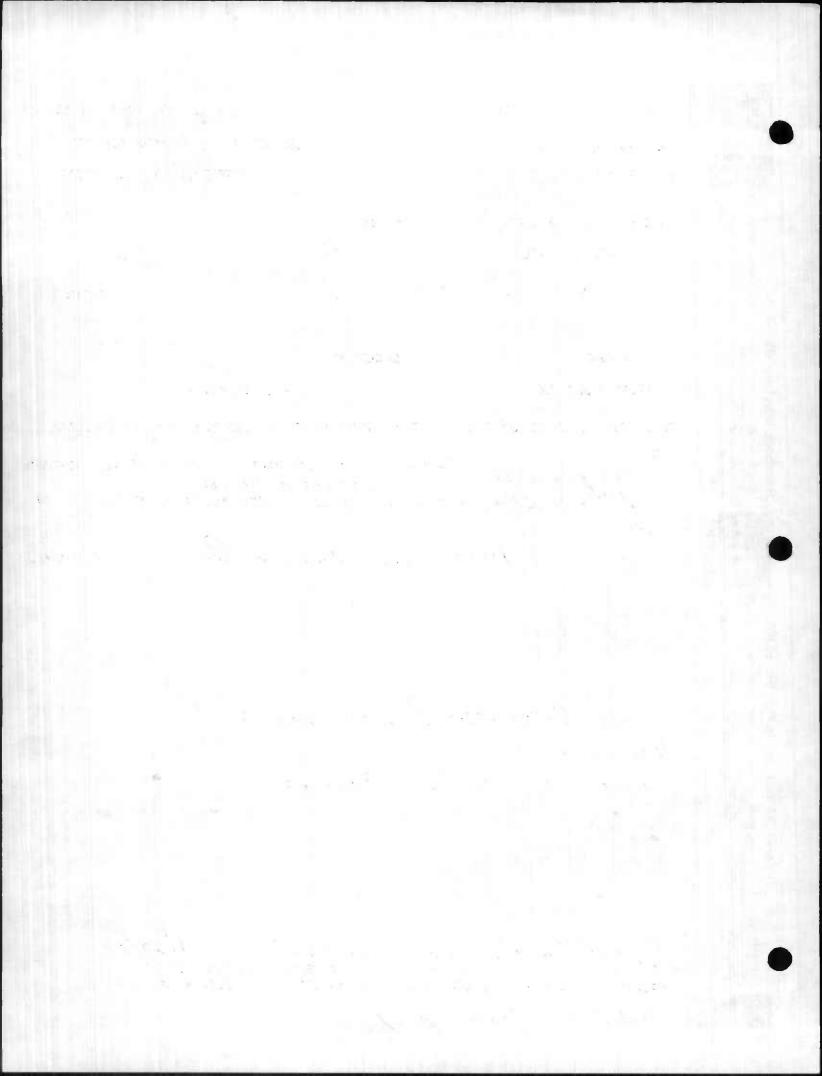
29c. License number

EMPIRE MEDICAL BUILDING

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

To the I within 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 9 1645 Arthur Lewis 0 4a Fecility Name (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Hospital Baltimore If Under 24 Hrs. 8. Dete Baltimore City Memorial mion If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 10℃M 2□ F Months Days Hours Min Yrs. MD 218-48-1065 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Baltimore MD NA 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? U.S.A. 21218 Street Apt 444 3501 St. Paul 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indien. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Detes: 3 □ Widowed 4 □ Divorced Black 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ yrs School System Teacher 12th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Melden Sumeme) Mary Franklin Robert Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3328 W Caton Ave, Baltimore Md 21229 Mary Johnson-Mother 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem Park 2/4/99 Arbutus, 21. Signature of Funeral Service Licensee 22. Name end Address of Facility March F/n west 4300 Wabash Ave, Baltimore Md 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one ceuse on each line. March F/H West B 21215 Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) 3days ehydration Due to (or as e consequence of): sepsis 1 Week Sequantially list conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Diseasa or Injury that initialed events resulting in death) Last Due to (or es e consequence of) Stage Aids -nd Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were eutopsy findings evalleble prior to 24e. Was en eutopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medicel examinar? 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homleide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Msdicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29e. Certifier

certificate be exect Division of Vital Records, P.O. Box 68760 Attanding Physician: death after b Hospital 75

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

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the Maryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show say higher or other traumatic event, the Medical Examiner must be not lied at once.

Physician /Medical

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Physician/Medical

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Certification:

29b. Signature and Ittle of certifie

raul

30. Name end address of person who completed

Kang

Baltimore,

Medical To the

DHMH 16 Rsv 6/95

State Registrar

Pkwy. Balb MD 21218 University

M.D.

use of death (Item 23a) (Type, Print)

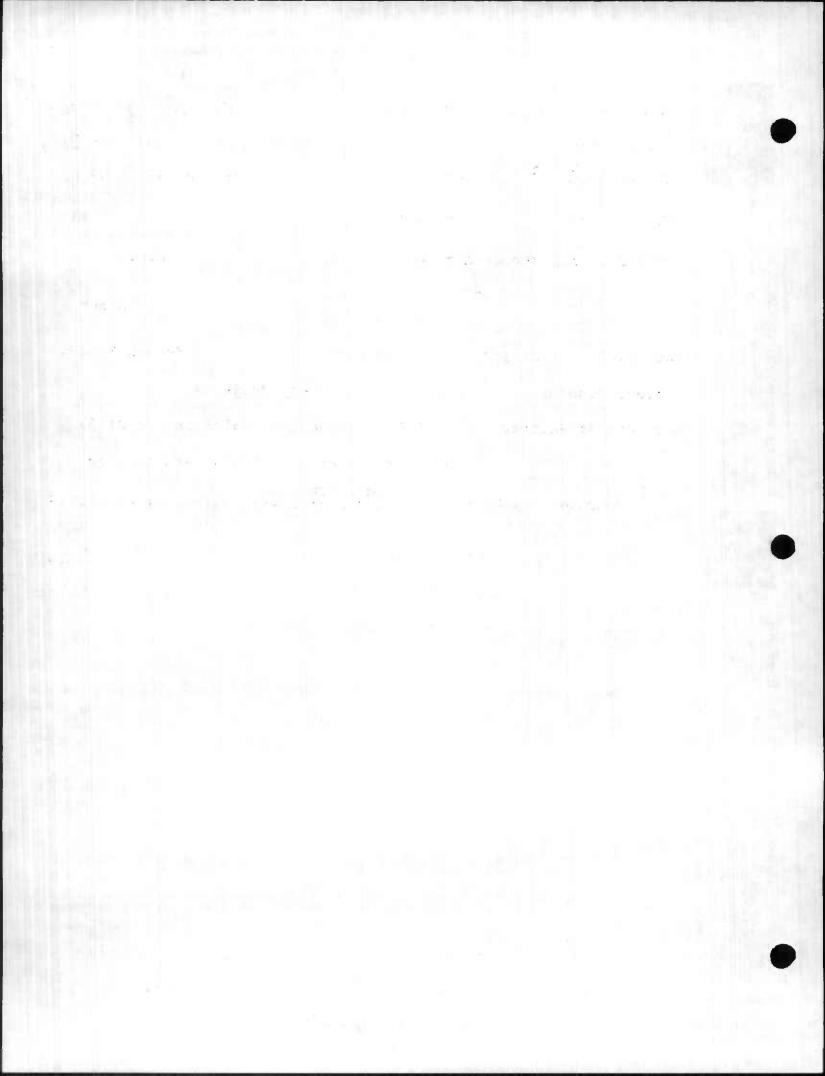
29c. License number

100053373

29d. Dete signed (Month, Dey, Year)

31. Dete liled (Month, Dey, Year) 32. Registrar's Signature FEB

201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 16a per F.H G-768 2/3/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** TANUARY 29, 1990 cation of Death 4c. County of Death JOCKSON Teorge /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) Examiner Baltmore
| H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Stella 5. Sociel Security Number Maris If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Months Deys 10 M 20 F Director 216-42-8242 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Md 1 No 2 No NA Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21215 Reisterstown U.S Koad 3000 Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 DNo H Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Black, White, etc. 1 Never Merried 2 Merried specity: Black 1 ☐ Yes 2 ☐ No Specify: 8 Baltimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) . Clothiers Jos A Elementary/Secondery (0-12) College (1-4or 5+) UK Bank Seamtress une 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be 2 should be fi and Mental F bert Pages 1 and 2 should nent of Health and Men Jackson -11 rabeth Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Balto, red 21215 Department of Health I Important: If Item 27 is any injury or other tra Sister 5214 Heights hinden Avenue 10400 20b. Plece of Disposition (Name of gemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Meyonal andallstown, ud 21. Signature of Funerel Service Downs 22, Name end Address of Fecility 21215 5.4. West 1300 Wabash grenue Ba Ito. Mel 23e. Mart1. Enter the disease, or demplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart leiture. List only one cause on each line. Approximete Intervel Between Onset end Daeth **Physician** /Medical Immediate Cause (Fine) Circhosin diseese or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Box 68760, thet initieted events resulting in death) Last Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Juspere à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Physician: 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Sella MH13 At MERCY Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence Other (Specify) Lossia Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28b. Time of Injury 27. Menner ol Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Neturel
2 Accident 5 Pending investigation Division or Attending 1 Yes 2 No deeth. after deeth 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, lerm, street, lectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30/41 D4085 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Balting. MD 21202 nond 31. Date liled (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Ray 6/95

Registrar

KSON

BALTIMORE

111 Penn Street, Baltimore, Maryland 21201

N/A

GLORIA		State of Marylar	nd / Department of Health and N	lental Hygi	ene no	717
JONES			Certificate of Death	Re	g. No.	111
	1. Decedent's Name (First, Mic	ldie, Last)		2. Date of Death		3. Tima of Death
Physician /Medical	CTOPIA	JONES		JANUARY	Dey Year 26,1999	2:05P.M.
	4a Fecility Neme (If not institut	ion, give street and number)	4b. City, Town, or L	ocation of Death	4c. County of Death	

UNION MEMORIAL HOSPITAL

Funeral Director

67 Usual Residence of Decedent the Meryland 10a. State 10c. City, Town or Location 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Directo MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 2206 ROSLYN AVENUE APT 5 21216 Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ØNo If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 à 3 X Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) NURSING 6th grade itam 27 is marked other other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other traumatic event page. 17. Father's Neme (First, Middle, Last) Be EDWAFD WILLIAMS 19a. Informant's Name/Relationship (Type, Print) Jennifer Winchester/Pauchter 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Mathod of Disposition Burial 2 Cremation 3 Removel from State KING MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Examiner Examiner iovascu physician and the bunal-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequenca of): Se 080 Po P.O. ed by tha a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Obesit Division of Vital Records. by Completed paga 2 s certificata has or Attending Physician: 25. Was case referred to medical examiner? Be Hospital: XXYas 2□ No 10 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA this funaral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending efter daeth. 1 Yes 2 No investigation 2 Accident 6 Could not be datarminad 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 Homicide 24 hours Hospital 29a. Certifier edicai compietely (Check only one) within 2 \$ 29b. Signature and title of certifie 29c. License number Laure O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aner es-

32. Registrar's Signature

3 1999

If Under 1 Yeer | If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) 1 M XXF Days Min 212-30-9934 Yrs. SEPT 16 1931 MARYLAND 10d. Inside City Limits 1 XXes 2 □ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, Whita, etc. Specify: BLACK 16b. Kind of Business/Industry HEALTH 18. Mothar's Nama (First, Middle, Meiden Surneme) LOUISE MONTAQUE 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2206 Roslyn Avenue Apt. 5, Baltimore Maryland 21216 20c. Location - City or Town, State 2-2-99 BALTIMORE, MARYLAND 22, Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death arteriosclerotic 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy nspection 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 1 Certifying Phyelclen: To the best of my knowledge, death occurred at the tima, date and pleca, and due to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) JANUARY 27,1999

Sparke

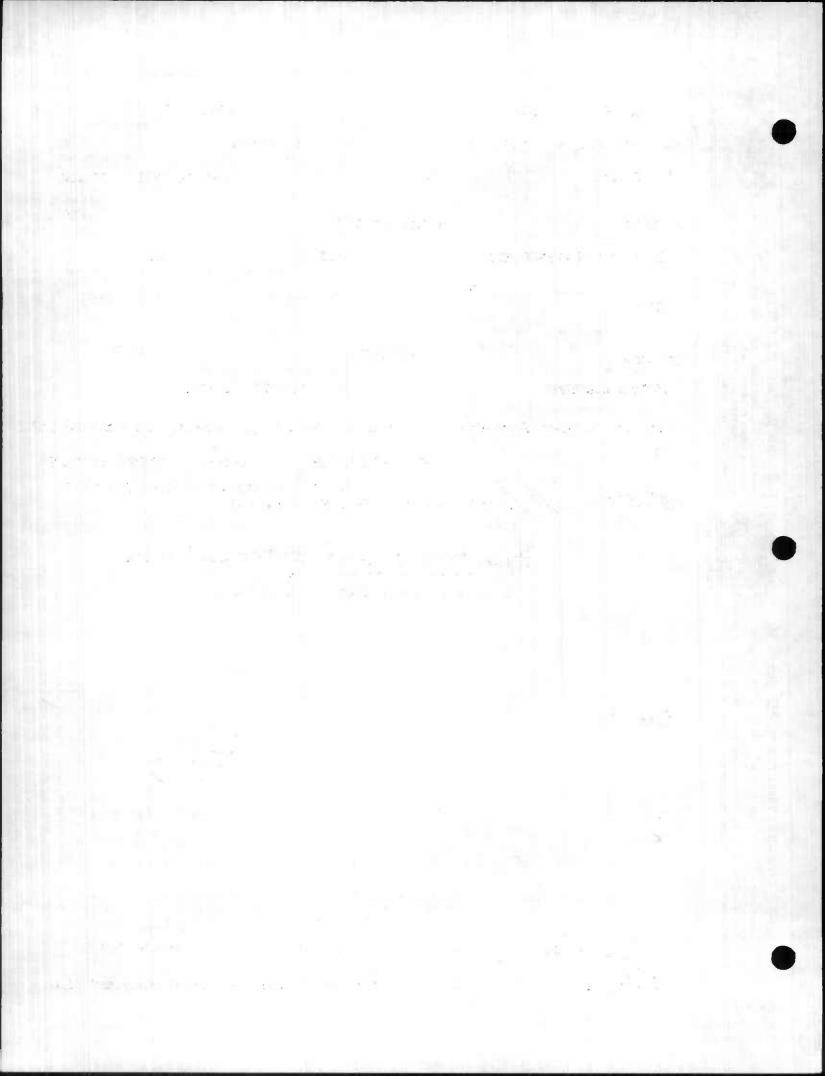
State Registrar

DHMH 16 Rev 6/95

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31. Date filed (Month, Dey, Year)

FEB



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item:20c per F.H G-768 2/9/99 reb Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey Month Year **Physician** 4:26 PM Marie Margaret Jendrasak January 31, 1999 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Gilcrest Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Deys Months Hours 1 M 2 F Director 215-14-9396 Jan. 20,1923 Maryland Usual Residence of Dacedan Marviend 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23s or 25s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21222 Funeral 3701 North Point Road Lot #34 United States death 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? pernit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiene. Important: If itsm 27 is merked other than "natural", or itse important: If the Welfred Examines to file Medical Examines Date. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White by 3 □ Widowed 4 □ Divorced Yeer or Detes: Completed 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede complated) 16b. Kind of Business/Induatry Elementery/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Thomas E. Biden Anna E. Reed 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Kathleen A. Doegen/Daughter 11 Virginia Ave.NW Glen Burnie, MD 20c. Location - City or Town, State 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete cemetery, cremetory or other place) 1 Burial 2 □ Cremation 3 □ Removel from Stete **FALLSTON** 4 ☐ Donetion 5 ☐ Other (Specify) Highview Mem. Gdns. 2/4/1999 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. alne 7922 Wise Ave. Dundalk, Maryland 21222 23a. Pert f. Enter the disease, or complications that caused the daeth. Do not entar the mode of dying, such as cardiac or raspirato shock, or haert failure. List only one cause on each line. Approximata Intarval Batween Onset end Death **Physician** /Medical tmmediate Ceuse (Final presmonia diseese or condition resulting in daath) **Examiner** Due to (or es e consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to immediate ceuse. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Lest Due to (or as a consequence of): Physician/Medicai Due to (or as e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco usa contributa to the cause of death? been signed by the should be deteched Division of Vital Records, P.O. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown mtarct dementia þ 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24a. Was an autopsy Completed hes pe 2 page 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate : After this certifical s funerel director. Hospital or Attending Physician:
24 hours efter death.
 Funeral Director: After this certific. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) + USFICE Hospital: 1 ☐ tnpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 1 Yes 2 No 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 1 Naturel 5 Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be datermined 28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the causa(a) and menner as stated.

2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, data and place, and due to the cause(s) edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) end menner ateted. 29d. Deta signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie 25205 30. Name and eddrass of person who completed cause of deeth (Item 23e) (Type, Print) N. Charles St. Balto med 21204

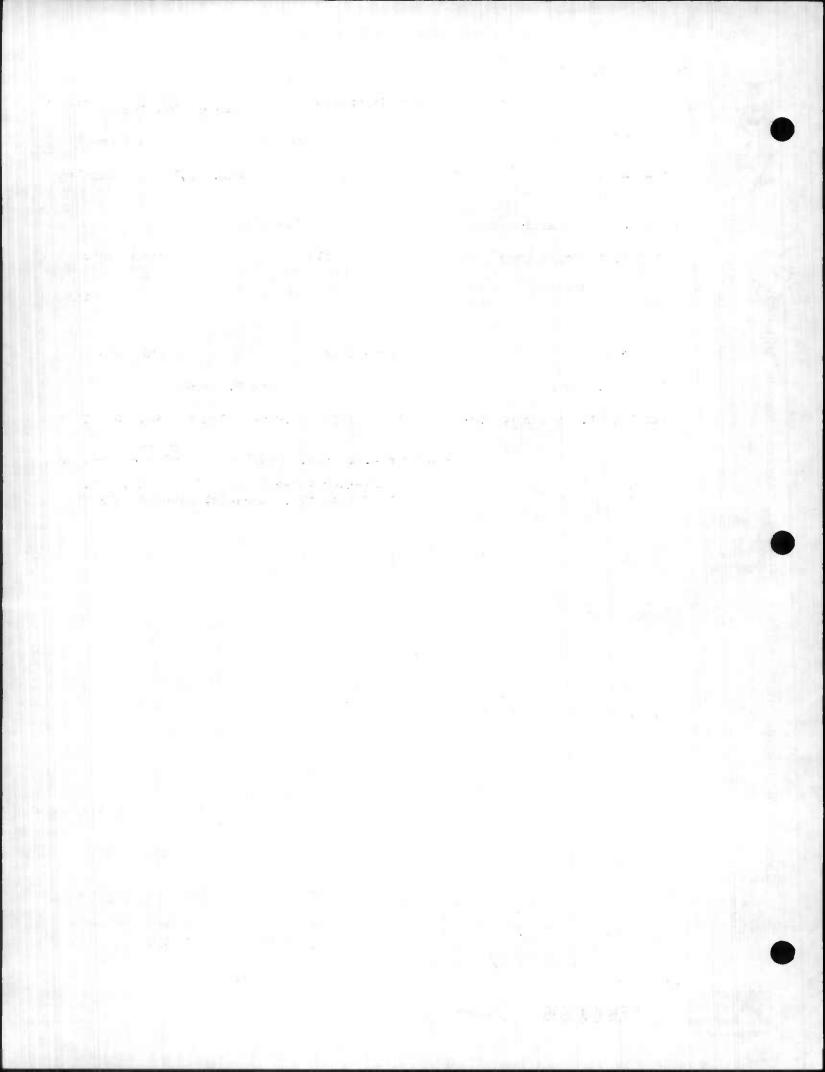
Registrar

31. Dete filed (Month, Dey, Year) FEB 0 3 1999

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82. Ragistrer's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician** CHARLES 7:40 PM KEITH January 6, 1999 /Medical Examiner GLEN BURNIE ANNE ARUNDEL 8. Date of Birth Day, Year) April 18, 1947 Maryland 9. Birthplace (State or Foreign Funeral 1€M 2□ F 51 216-10-6001 Director **Usual Rasidence of Decedent** 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show Anne Arundel Glen Burnie 1 ☐ Yas 2 No Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21061 U.S.A. 126 Southbridge Drive Berns 23a 12. Was Decedent Ever in U,S. Armed Forces? 1↓ Yes 2 □ No HYes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Biack, Whita, atc. filed within 72 hours after Hygisna. ther than "natural", or the 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien, Important; if Item 27 is marked other tha any Injury or other traumatic - other tha angles. UNKNOWN UNKNOWN 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) 98 Charles Keith Sr. Aldey Sliakis 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Lowman/sister 525 Post Oak Road, Annapolis, Maryland 21401 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of Farecas Service Lourses Wade, Director 22, Nama and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Hartt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart tellure. List only one cause on aach line. Approximate Interval Between Onset and Death Physician PANCREATIC LANCER WITH METASTASES Immediata Causa (Final diseasa or condition rasulting in death) /Medical Examiner TO THE LIVER Physician/Medical Examiner ARYNGEAL CARCINOMA physician and the burial-transit The law requires that the death certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Due to (or as a consequence of) P.O. 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yea 2 No 3 Probably 4 Unknown Records, Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2₽No 1 Yes 2 No Division of VItal or Attending Physician: 25. Was case refarred to medicat axaminar? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yas 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 27 1999 DS1104 INTERNAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 CRAIN HIGHWRY S. W. SUITE 208 CILENBURNIE, MD 21061 SRIHARI VEMULAKONDA

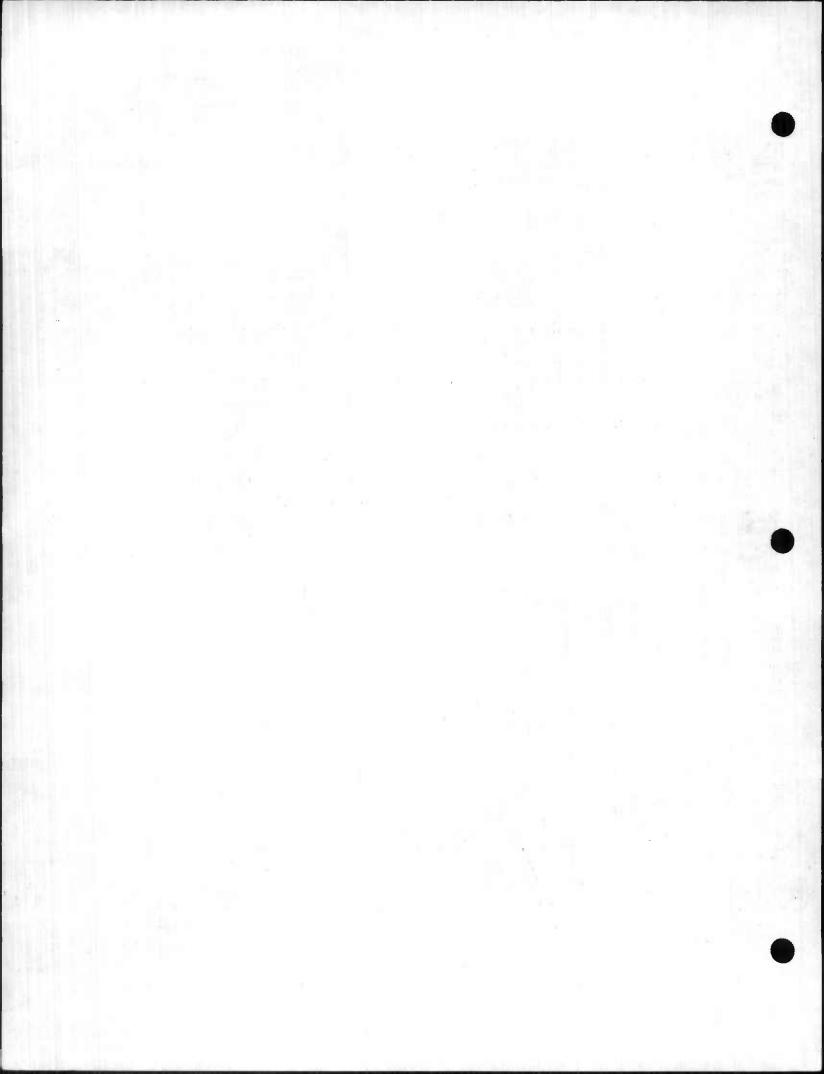
DHMH 16 Rev 6/95

State Registrar

31. Data filed (Month, Day, Year)

FEB 0 3 1999

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene() Certificate of Death 3. Tima of Death 2. Date of Death 1. Decedant's Name (First, Middle, Lest) Month **Physician** 2:03 AM tebruary HERBERT B. KIRTSCHER JR. /Medical 4c. County of Death 4b. City Town, or Location of Death 4a Fecility Nama (If not institution, give street end number Examiner entel Square a ranklin Age (In yrs. last birthday) If Undar 1 Yaar Birthplace (Stata or Foreign Country) Sex 5. Social Security Number **Funeral** Months Days Hours 10XM 20 F 219 36 1075 **Director** ллу 19 1941 MARYLAND Usual Residence of Decedant 72 hours after death with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a State 10b. County 1 ☐ Yes 2 No Director BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? realities 7923 31st 21237 USA Funeral . 1 and 2 should be filed within 72 hours after deat Health and Mental Hygiene. em 27 is marked other than "natural", or items 2 ther fraumatic event, the Medical Engine or Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amarican Indian, 12. Was Decedent Ever In U,S. Armed Forcas? 1 √Yes 2 No If ¥s, Give 11. Marital Status Black, White, etc. 1 Nevar Married 2 Married 1 Yas XXNo Specify: Specify: WHITE by 3 Widowed 4 Divorced Year or Datas: VIETNAM Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry 15. Decedent's Educetion (Specify only highest grade complated) College (1-4or 5+) Elemantary/Secondary (0-12) 0 +eRbert DISABLED DISABLED 18. Mother's Name (First, Middla, Meidan Sumema) 17. Father's Nama (First, Middle, Last) Be HERBERT HENRIETTA MARTIN B. KIRTSCHER SR. 19a. Informent's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat end Number or Rural Route Number, City or Town, Stete, Zip Code) JOAN V. KIRTSCHER/ WIFE 31st STREET BALTIMORE. MD 21237 20b. Place of Disposition (Neme of cametary, crametory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h 1⊠ Burlal 2 ☐ Cramation 3 ☐ Removal from State DULANEY VALLEY MEMORIAL 2/5/99 4 ☐ Donation 5 ☐ Other (Specify) TIMONIUM, MD 21. Signature of Funerel Service Lice CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTO, MD 21237 or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arre. List only one cause on each line. 23a. Part1. Enter the disput **Physician** /Medical Immediate Cause (Final 5 Years diseasa or condition rasulting in daath) Examiner Examiner enscor physician and the burial-transit Sequantially list conditions, if any, teading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Lest Due to (or as e consequence of) Physician/Medical Due to (or as e consequence of): 88 use Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Wara autopsy findings evailable prior to completion of ceuse of death? Completed 24e. Wes an autopsy certificate has lirector, page 2 s 2 10 1 Tas 1 □ Yes 2 □ No Hospital or Attending Physician: director 25. Was cese referred to medical Be 26. Placa of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 22 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After Natural 5 Panding after death. 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, straat, fectory, office building, atc. (Specify) 4 Homicida 24 hours a Funeral I TCertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. | Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. To the Hospi within 24 hou To the Funer completely fil edicai 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and titla of certifier 135761

nplated cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Johns

- vew CA Balt MD 21224

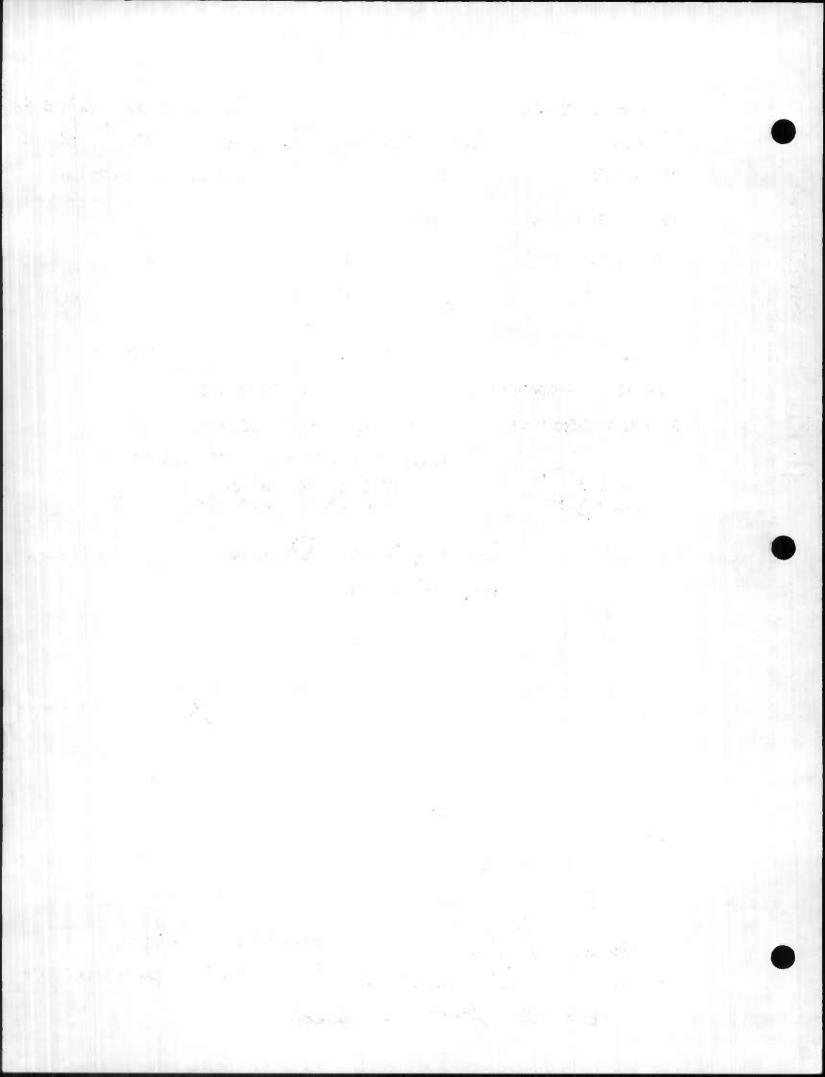
State Registrar 30. Name and addrass of parson who co

31. Date filed (Month, Dey, Year)

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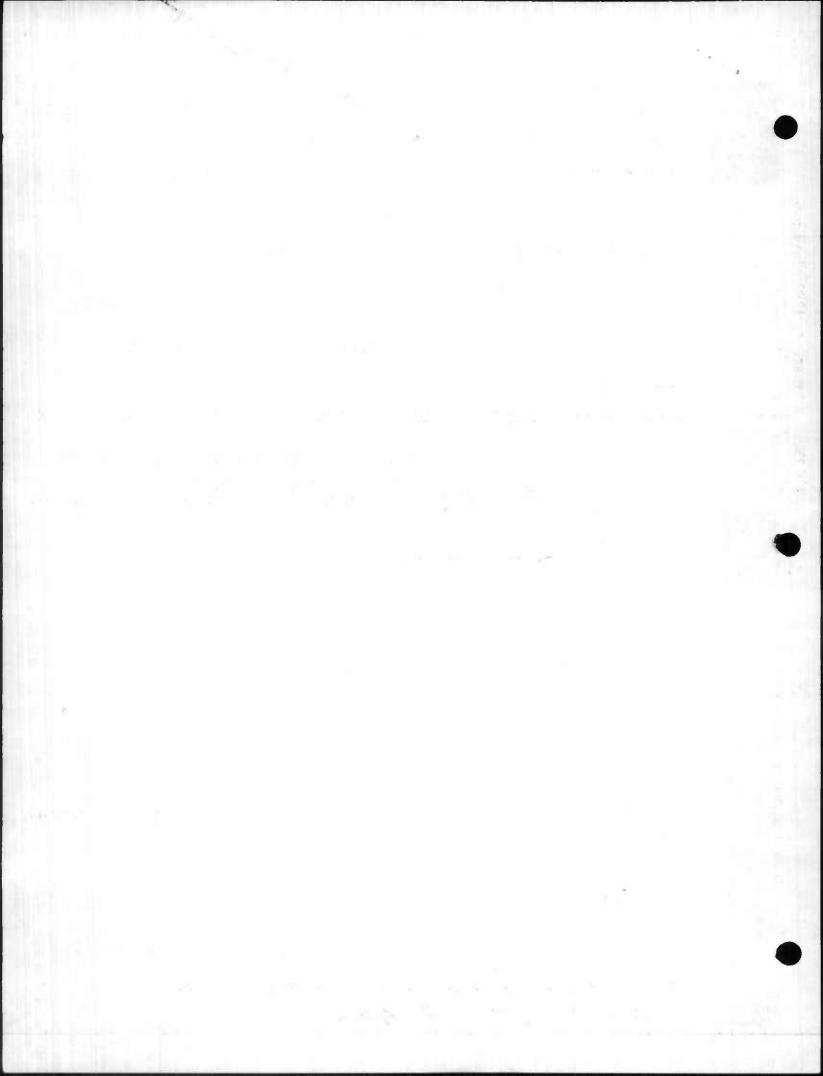
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within 72 hours after death with the Maryland ene . than 'natural', or Items 23s or 28s-f show the Medical Examine must be notified as	by	11. Maritai Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Decedent Endem of Forces? 1 Yes XXNo If Yes, Give Yaar or Dates:	ver in U,S.	13. Was Decedent If Yas, specify C	of Hispenic Origin? (Sp Cuban, Mexican, Puerto ¶o <i>Specify:</i>	ecify Yas or No Rican, etc.)	D- 14. Rac Bla Specif	ce - Amarican ck, White, etc.	
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00000	_	19a. Informent's Name/Relationship BARBARA THERRES				eet and Number or Rui	rel Route Numb	per, City or Town, IMORE, M	, State, Zip Co IARYLAN	^{de)} 21224
permit. Peges 1 and Department of Health Important: If Itam 27 any injury or other trans.		20a. Method of Disposition 1 ፟ Buriai 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Othar (Spe		cemetery,	isposition (Neme of cremetory or other OLY REDEE)	pleca)	Dete 2/4/99	20c. Location -		
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hysician be executed by physician physician and physician and street physician are the buriel-transit	al Examiner	Immediate Ceusa (Final diseasa or condition resulting in deeth) Sequentially list conditions, if any, leeding to Immediata causa. Enter Underlying Ceuse, (Disease or Injury	b	rasular A	nsequanca of):					
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or Atte	-	27. Manner of Deeth 1 XNaturai 5 Pending 2 Accident investiga	28e. Date of Injury (Month, Day	28b. Tim	a of 28c. I	njury at Work?		how injury occur		HOSPICE
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le		30. Name and addrass of person with DR. TARIQ MAHM				TIMONIUM,	MD 21	093		
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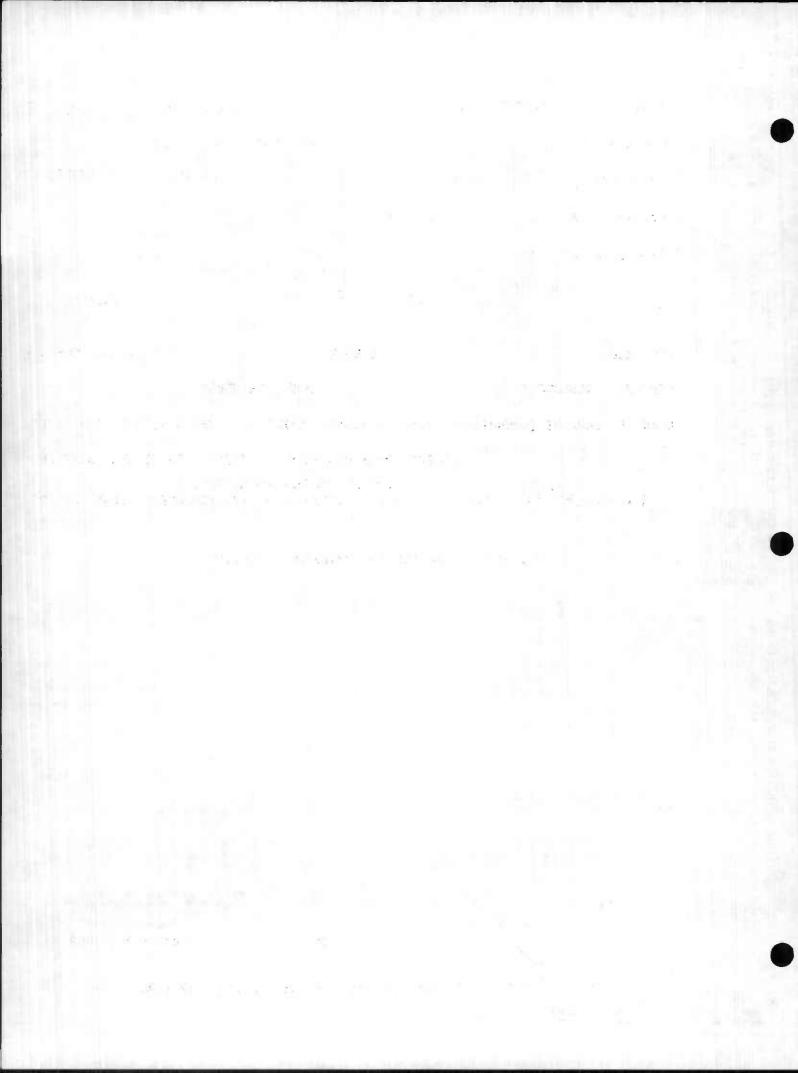
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Baitimore, Maryland 21215-0020

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Division Attending Examiner Physician/Medical P Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1月 Yes 2□ No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

P12703

JAN 27, 1999

HOREA RUS MD

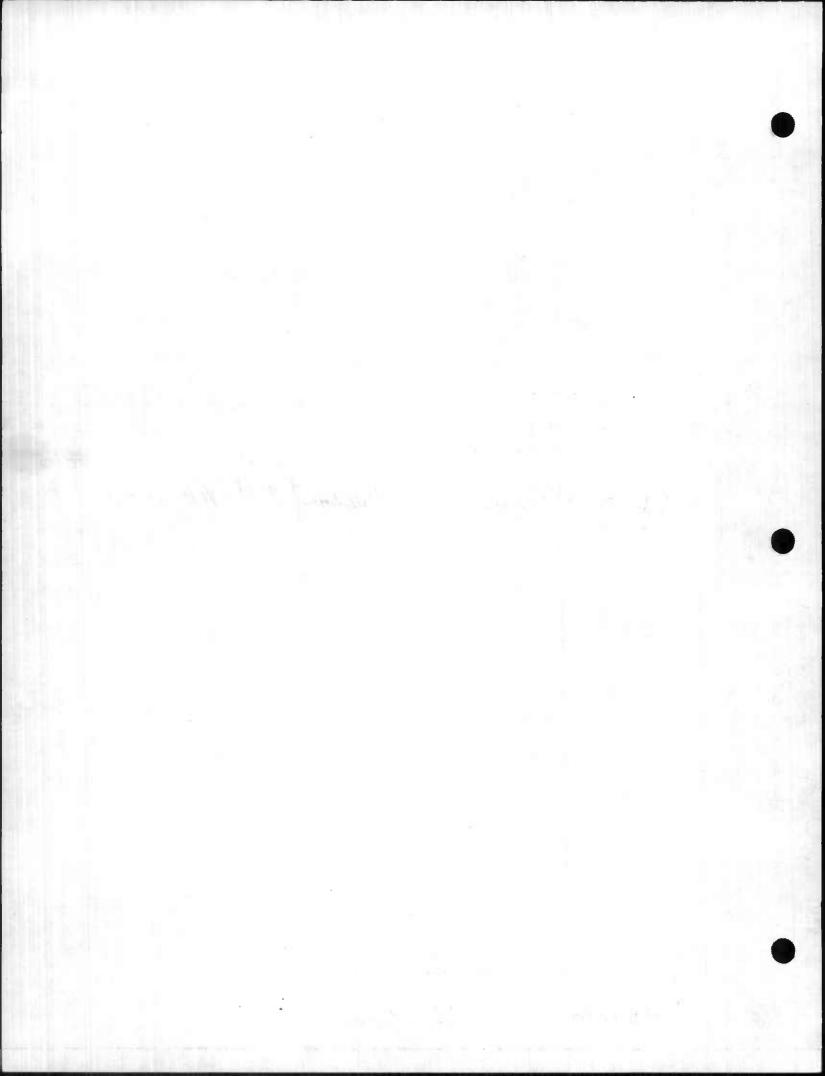
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVE, BALTIMORE ST. AGNES 40SP.

State Registrar

HOREA RUS, 31. Date filed (Month, Day, Year) FEB 0 3 1999

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 9 Per FH Film G768 2-3-99 rja Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DORIS 2:05 p.m LEIMBACH 01 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death MONTGOMERY BETHESDA HOSPITAL SUBURBAN If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 5. Sociel Security Number Months 1 □ M 2 17 F 217-14-0504 85 Yrs. 05/27/1913 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20814 5225 Pooks Hill Road 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) 12 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Luke Alcon Fisher Myrtle Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Brian Leimbach/son 5225 Pooks Hill Road, Bethesda, Maryland 20814 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Van Sant 22. Name end Address of Facility
State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediete Ceuse (Final disease or condition resulting in death) Le hours 10 day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting In death) Last Due to (or as a consequence of): Disease 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Pneumonia 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Diverticulities Septicemia 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 PInpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Yes 2 No

The law requires that the deeth certificate be executed attending physician end for use es the bunal-transi Division of Vital Records, P.O. Box 68760. 68 the s 6 been

Physician

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Physician

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Examiner

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from 27 is marked other than "natural", or flema 23s or 28s-f shot other traumatic event, the Medical Example for man be notified as

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Haelth and Mantal Hygiens. Important: If fem 27 is marked other than "natural; or flema 23a and july or other traumatic event, the Made

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within 24 hours effer deeth.

To the Funeral Director: After this certificate has funeral director, or Attending filled in by

Doris 2:05p.m.

Leimbach, Exoral/23/99

1 Yas 2 No 27. Menner of Death 1 Netural 2 Accident 3 Suicide 4 Homicide

Physician/Medical 2 Completed Be To Certification: edicai

Examiner

29a. Certifier (Check only one) 5 Pending Investigation

6 Could not be determined

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

BETHESDA

1 🗹 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner es stated 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier

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MD

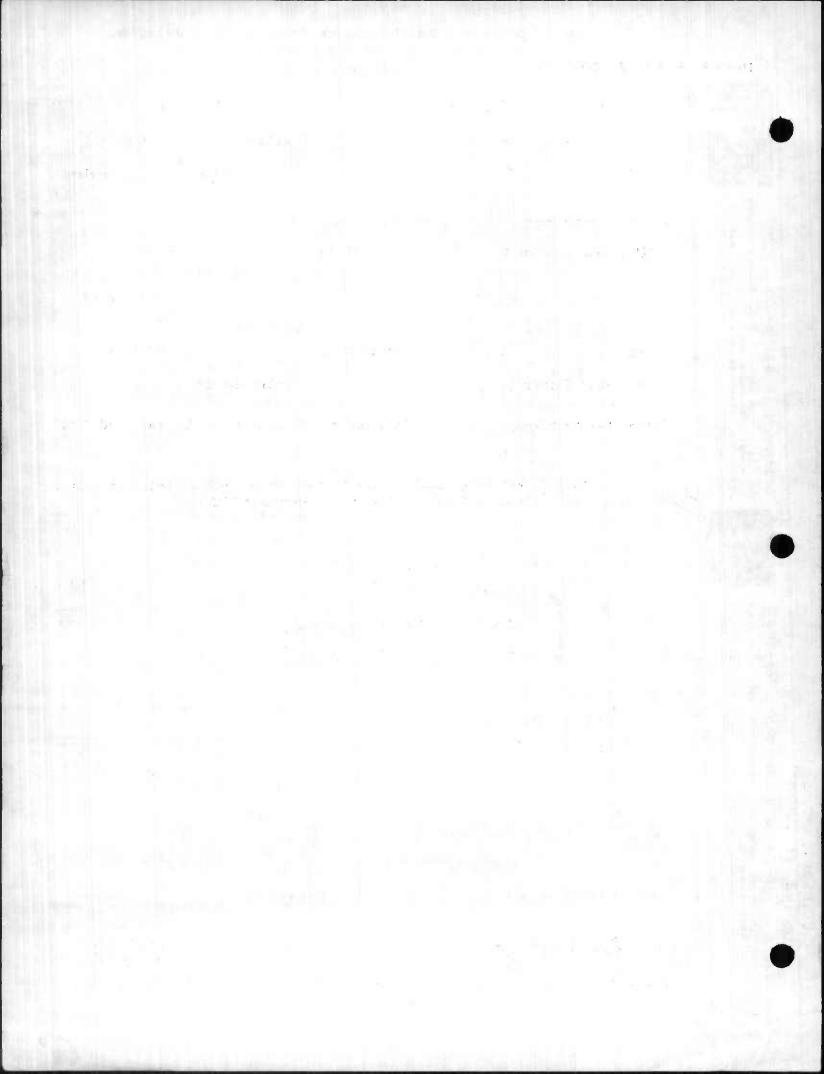
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) IRONY, HILL RD. #1 MI 5225 POOKS

31. Date filed (Month, Dey, Year)

32. Registrer's Signature

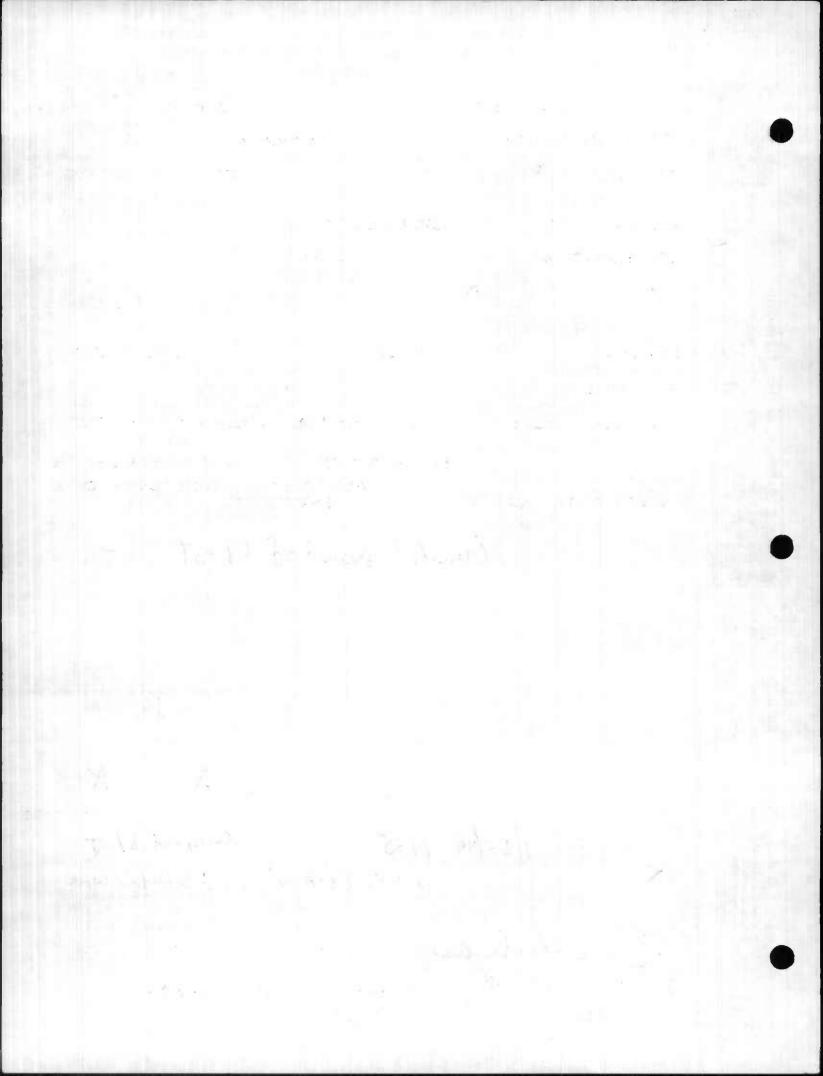
Registrar

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State of Maryland / Department of Health and Mental Hygiene*

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ING Z I Z I 3-UUZU be filed within 72 hours after death with the Maryland tal Hygiena d other than "natural", or frems 23s or 23s-f show event, the Medical Exertment must be notified at	by	1 ☐ avar Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X If Yas, Giva Yeer or Detes:		1 ☐ Yes			5 (110 a.i., 5 (5.),	Specify		
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Dalitimore, Maryland 21213-0020 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiena. If Item 27 is marked other than "natural", or any injury or other traumatic event, the Maulital Exam.	Completed	Elamantary/Secondery (0-12) 12th grade	Collaga (1-4or		<i>lifa. DO NOT</i> u LUMBER	se retire	d)		HASSAN	PLUN	BING
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K OO/OU, artificate be executed ing physician and e as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest	c		consequence of):						
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Or VII.di neco Physician: The law rthis certificate has t) Be	25. Wes cese referred to medical examiner?	Hospital:			Oth	har	ith (Check only on		(0	ALL COUNTY
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Attending or death.	ation	1 □ Naturel 5 □ Pending investigatio		19 /c	555 M		Yes 20 No	Suh	et.	820	t
To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Certification:	3 Suicide 6 Could not be datarmined	250. Piece ovin	jury - At home, f ic. (Specify)	arm, street, factor	y, office	JALD)	28f. Location (Sinciple) City or Tow	treet end Numi	ber or Rure	el Route Number,
To the Hospital or within 24 hours after To the Funeral Direction	edical C		ysician: To the best niner: On the basis of	f axamination e							
ithin ithe	Mec	29b. Signeyare and title of certifier	end menner st		29	c. Licens	se number	2	9d. Data signe	ed (Month,	Day, Year)
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Regis		FEB 3		Jenera	B.	100	akal				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month EB **Physician** LEPOCK MILDRED /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Church Hospital Baltimore City 7. Age (In yrs. last birthday)

RR Yrs. Months Deys Hours Min. (Month, Dey, Year)

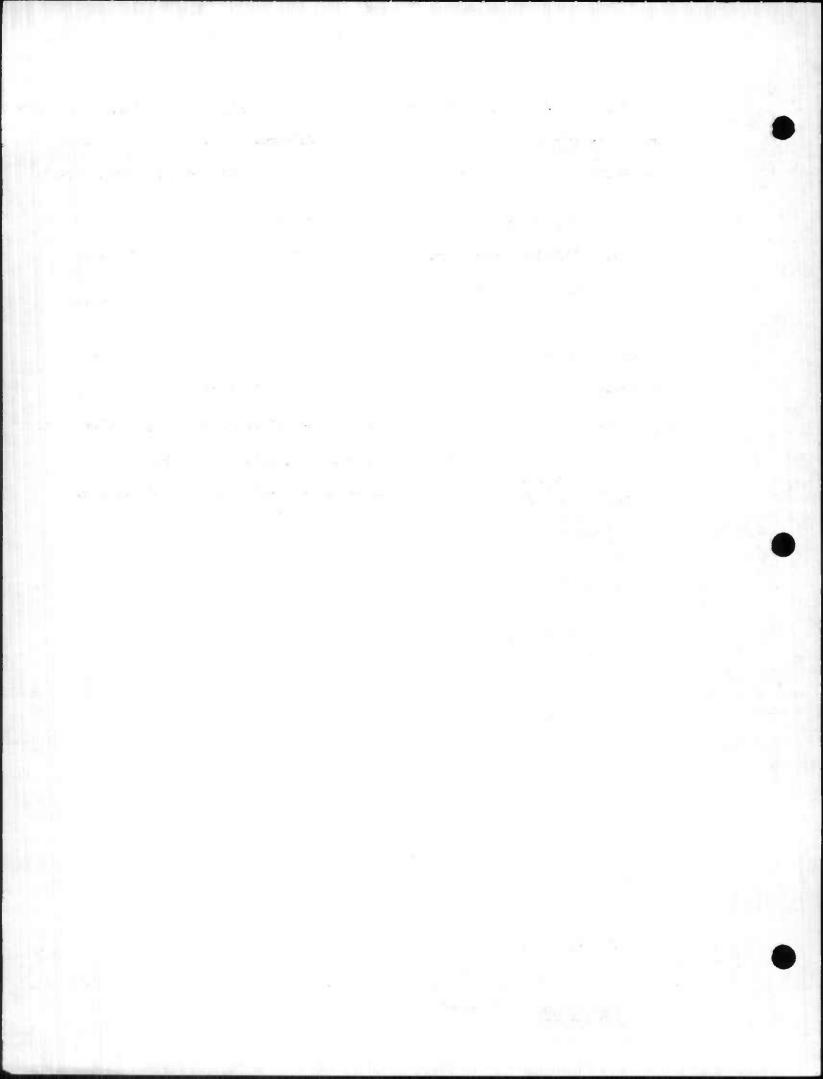
March 16,1915 5. Social Sacurity Number 9. Birthplece (State or Foreign Country) Pennsylvania **Funeral** 1□M 2∯F 236-90-9206 Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limita 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Madical Examiner must be notified at 1 □ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 7828 West Collingham Drive Apt. C 21222 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian, Bleck, White, etc. e filed within 72 hours after all Hygiene. 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detes: 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementary/Secondery (0-12) College (1-4or 5+) Years Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Nem 27 is marked othe any Injury or other traumatic event 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surnama) Nick Bekis Mary Fiesch 19e. Informent's Name/Ralationship (Type, Print) 19b: Melling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 2524 West Woodwell Road Dundalk, Maryland Pete Lepock 21222 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta Date 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Shinnston Masonic Cem. 2/5/99 4 □ Donation 5 □ Other (Specify) Shinnston, WV 21. Sonature of Funeral Service Linensee. 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 100 medical provided by the death of the death of the mode of dying, such as cardiac or respiratory arrest, Approximate Intervel Between Onset and Death **Physician** Immediete Cause (Final diseesa or condition rasulting in deeth) /Medical · METASTATIC CANCER OF LIVER Examiner Examine physician end is the buriel-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Dua to (or es a consequance of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown CHRONIC LUNG DISEASE. Records, 24b. Ware autopsy findinga evallable prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yas 2 No Division of Vital al or Attending Physician: The safter death.

In Director: After this certificate of in by the funeral director, pa 25. Wes casa ratarred to medical Be 26. Pleca of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 Tes 2 No invastigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28e. Pleca of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours a
To the Funeral C
completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(a) and menner as atated.

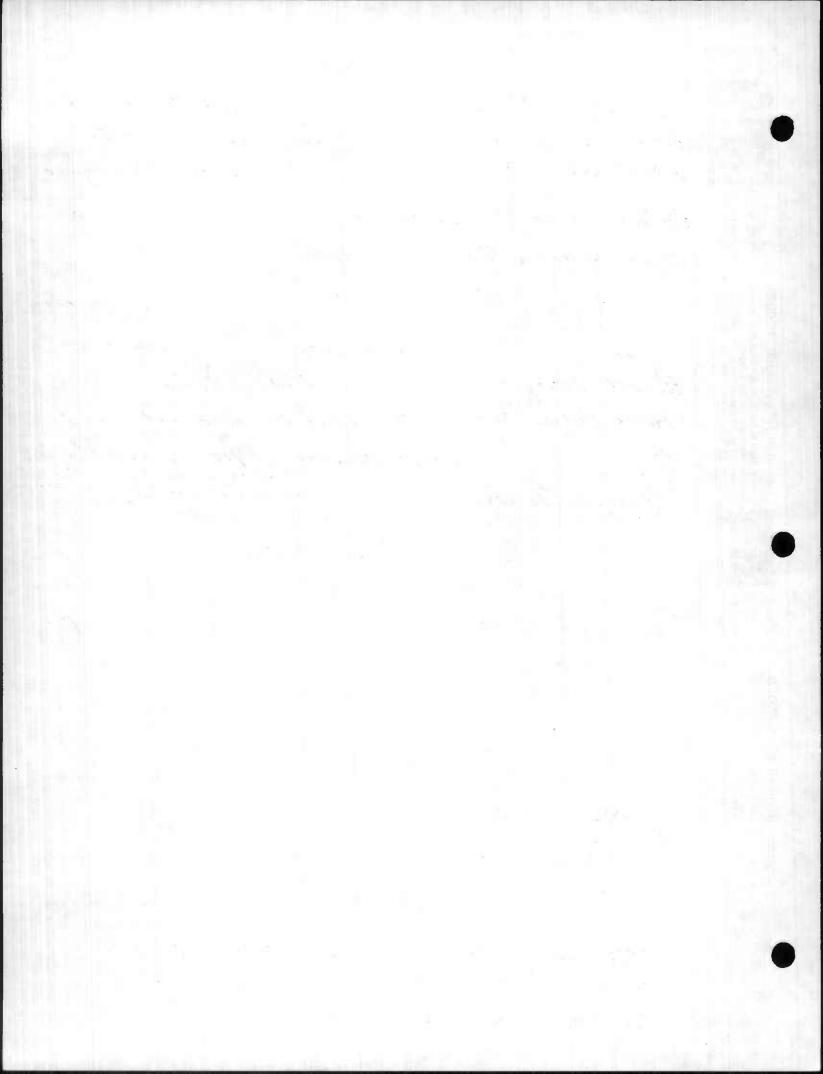
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, dete and pleca, and due to the cause(s) end mannar atated. 29e. Certifier To the 29b. Signeture end title of certifier 29c. License number 29d. Dete algned (Month, Day, Year) Nazemi no D17322 FEB, 151, 1999 30. Nama end address of person who completed ceusa of death (Itam 23a) (Type, Print) VAZEMI, M. G. HUNCH HOSPITAL, BALT.MO.
32. Régistrar's Signature G. Daniel TAOLLAH 31. Date tiled (Month, Dey, Year) 32. Registrar's Signature State FEB Q 3 1999 Registrar

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 30 0022 JAN MOORE /Medical 4b. City, Town, or Location of Death 4a Escility Name (If not institution, give street and nymber) 4c. County of Death **Examiner** none SECOURS Altimore Hospital 9. Birthplace (State or Foreign Country)
VIRGINIA If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number **Funeral** 1□M 2XF Days Months Hours 220-66-01 45 DEcember 9 1953 Director Usual Residenca of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10ar State 7 is merked other than "natural", or items 23s or 28s-f abov traumstic event, the Medical Examiner must be notified at BAltimore Yes 2□No none Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3021 CASA 2/2/6 Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status permit. Pages 1 end 2 should be filed within 72 hours effer of Department of Health end Mentel Hygiene. Introcrant: If flem 27 la merked other than "natural", or flen any Injury or other traumatic event Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2□ No Maryland 21215-0020 Specify: þ 3 Widowed 4 Divorced AMERRIA 16b. King of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Oces Home ome maker 12/1 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Malling Address (Street end Number or Aural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42/20 AUE -BAHO Md Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Voshells Memorial 21. Si na pre of Funerai Service Licensee WALLACE FUNERAL 22. Name and Address of Facility (Ance) m. 54/0 laller Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Heart Failure RUIS disease or condition resulting in death) **Examiner** Examiner lears Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ears Division of Vital Records, P.O. Box 68760 physicien Physician/Medical the 98 for use 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. signed by t d be detect 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? pege 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director. 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred After 1 Natural 5 Pending Investigation 24 hours efter deeth. 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number Kal 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 2305 Howard charles 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State Registrar



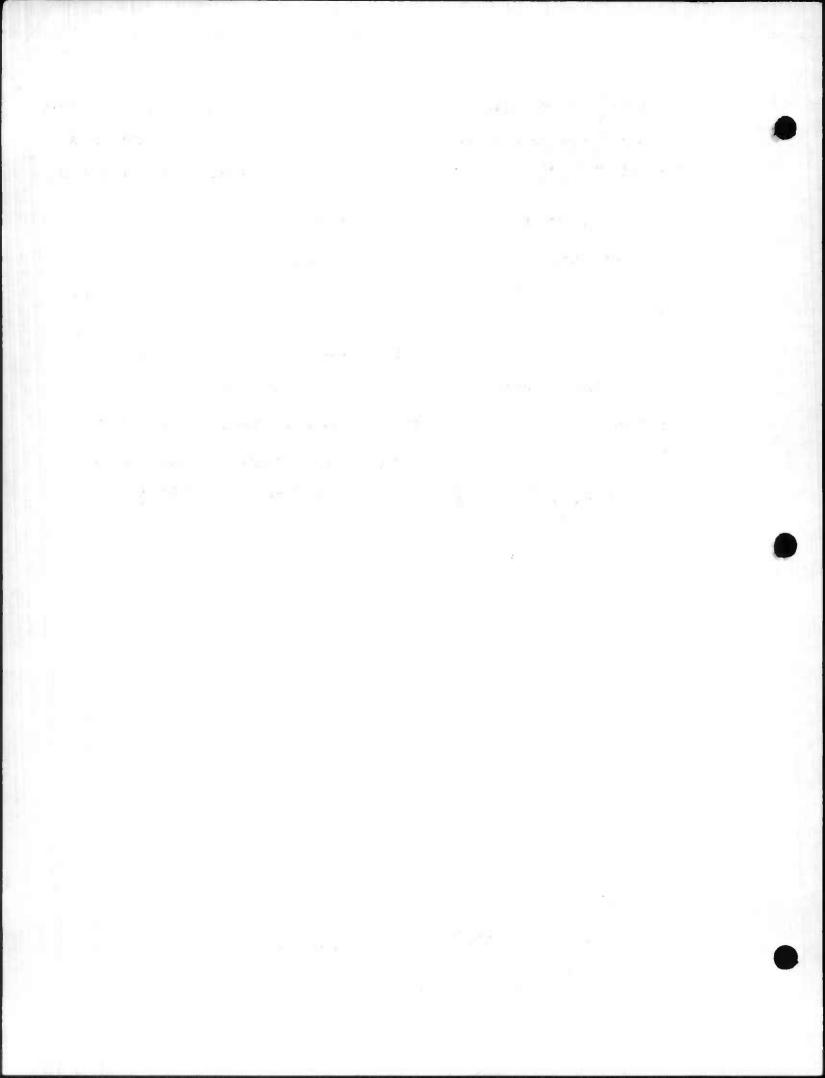
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Death 3. Time of Deeth 29 ey 199 yaar **Physician** Jan. Arville W MArkland 6:51pm /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Franklin Square Hospital Rosedale Baltimore If Undar 1 Yaar If Undar 24 Hrs.

Months Deys Hours Min. 8. Date of Birth (Month, Dey, Yeer) Sept. 5 1931 Birthplace (State or Foreign Country)
 Tenneessee 7. Aga (In yrs. lest birthdey) **Funeral** Months 10XM 2□ F 409-50-0119 67 Yrs. Director Usuei Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or itsma 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9 Floral Place 21220 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yas, Giva Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bieck, White, etc. 11. Maritai Status filed within 72 hours after 1 Never Married 2 Merried altimore, Maryland 21215-0020 White 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygians. Eiementery/Secondery (0-12) College (1-4or 5+) Produce Manager Food Store s 1 and 2 should be filed w I Health and Montal Hygier tem 27 is marked other th 12th 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middla, Meidan Surnema) James Garfield Markland Haley Elliott 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) Department of Health as Important: If Nem 27 is a 9 Floral Place Ruth Markland / wife Baltimore Maryland 20b. Piece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 █ Buriei 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Holly Hill Cemetery 2/2/99 Baltimore Md. 21. Signature of Funerei Service Licenses 22. Neme end Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 23a. Part1. Enter the disaasa, or composhock, or heert feilure. List ons that caused this death. Do not enter the mode of dying, such as cerdiec or Approximate interval Betw Onset and Deeth **Physician** immediete Ceuse (Finei disease or condition resulting in deeth) /Medicai 655ill Examiner Due to (or es a consequence of) Physician/Medical Examiner CABG physician and s the burial-transit the death certificate be axecuted Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Box 68760, Toiselle Nea thet initiated avents resulting in deeth) Lest Dua to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown à 24b. Were autopsy findings available prior to complation of cause of deeth? 24a. Was an autopsy performed? Completed peen hes 1 Tyas 2 No 1 □ Yes 2 □ No certificate Division of Vital 25. Was case referred to medicei examiner? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 Ø ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? After To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and eddress of persop who completed ceusa of death (item 23a) (Type, Print) 9 B. Bus BALT LOD 2/22/ 2 Miorui 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State 3 1999 Registrar

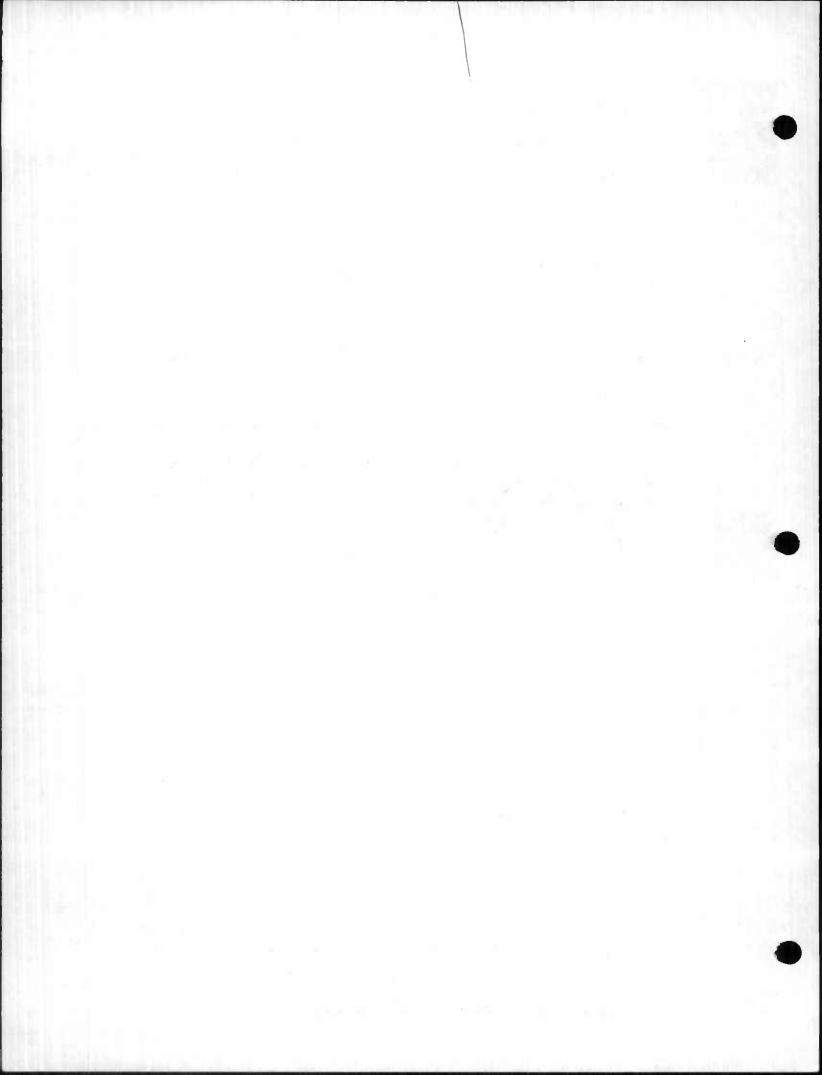
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Т	Funerai		5. Sociel Security Number 6. Sex		s. lest birthday)	If Under 1 Y	eer If Under 24 Hrs		th Year)	Birthplece (Stete or Foreign Country)
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	anyla	_		10c. C	city, Town or Lo	cation				10d. Inside City Limits
	M of	cto	Maryland	Bal	ltimore					1 □XYes 2 □ No
	₩ \$ 00 K	Pic	10e. Street and Number			10f. Zlp Cod			10g. Citizen of Wh	et Country?
	ath v	Funeral Director	2951 Rosalind Ave.			2121			J.S.A.	
	er de	une		 Wes Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☐ Wo 	U,S. 13.	Was Decedent If Yes, specify (of Hispenic Origin? (S Cuben, Mexicen, Puer	Specify Yes or No- to Ricen, etc.)	- 14. Rece - Black,	American Indian, White, etc.
20	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Examinar must be northed.	by F	1 Never Merried 2 Married	If Yes, Give		1□ Yes 2□X				Black
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e,	1 and 2 Health em 27		20a. Method of Disposition			sition (Neme o	d Ave., Ba	Deta Deta	20c. Location - Cl	
Baltimore,	permit. Pages 1 a Department of Hei Important: If them any injury or othe		1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Re	anovernoni State			1			
	permit. Pag Department Important: I any Injury o		4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Lidense		ryland	Nat'I	Memorial (02/01/99	Laurel,	Maryland
Ba	permit. Departnimports any inju		1/	0	1. 0	11 Dow	le Undahan	e Derric	k C. Jon	es Funeral Hm.
			Sound	C. Jane	- 40	oli Par	k neights	Ave., bal	timore,	Maryland 21215
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_6	death certificate be axecuted eatending physician and of for use as the bunal-transit	Xa	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceusa (Disease or injury	Due to (or es e conseq	juence of):				
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S, P		by P						10	Yes 2□ No 3	Probably Unknown
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of			27. Menner of Deeth	28e. Dete of Injury	28b. Time of		njury et Work?	1	now injury occurred	
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Division	or Attending after death. Director: After I in by the fune	if Co	3 ☐ Suicide 6 ☐ Could not be	28e. Plece of Injury - At h		eet, factory, off	ice			or Rural Route Number,
ā		Certification:	4 ☐ Homicide daterminad	building, etc. (Speci	ity)			City or Tou	vn, Stete)	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in		29a. Cartifiar 12 Certifying Physic	cian: To the best of my kno	owledga, daath	occurred et th	e tima, data and place	e, and dua to tha	ceuse(s) end mann	er es stated.
	n 24 n Fu ne Fu	edicai	(Check only 2 Medical Examine one)	er: On the besis of exemina end manner stated.	ation and/or inv	estigation, in n	ny opinion, daeth occi	urrad et tha tima,	dete and piece, and	dua to the causa(s)
	To the within 2 To the comple	×	29b. Signeture and title of certifier	C L		29c. Lic	ense number		29d. Deta signad (Month, Dey, Year)
	0		Hose J	COOTA, M	17	1	42634	1	LEB 1	1999
	1	1	30. Name end address of person who con	pleted causa of deeth (Ite	m 23e) (Type,	Print)	-	· ·		
	7		JOSEPH J OS	Α	ST F	PAUL P	LACE !	BACTIN	one no	21202
	Sta		31. Dete filed (Month, Dey, Yeat)	32. Registrer's Sign	eture 4	lan	1		-4	-
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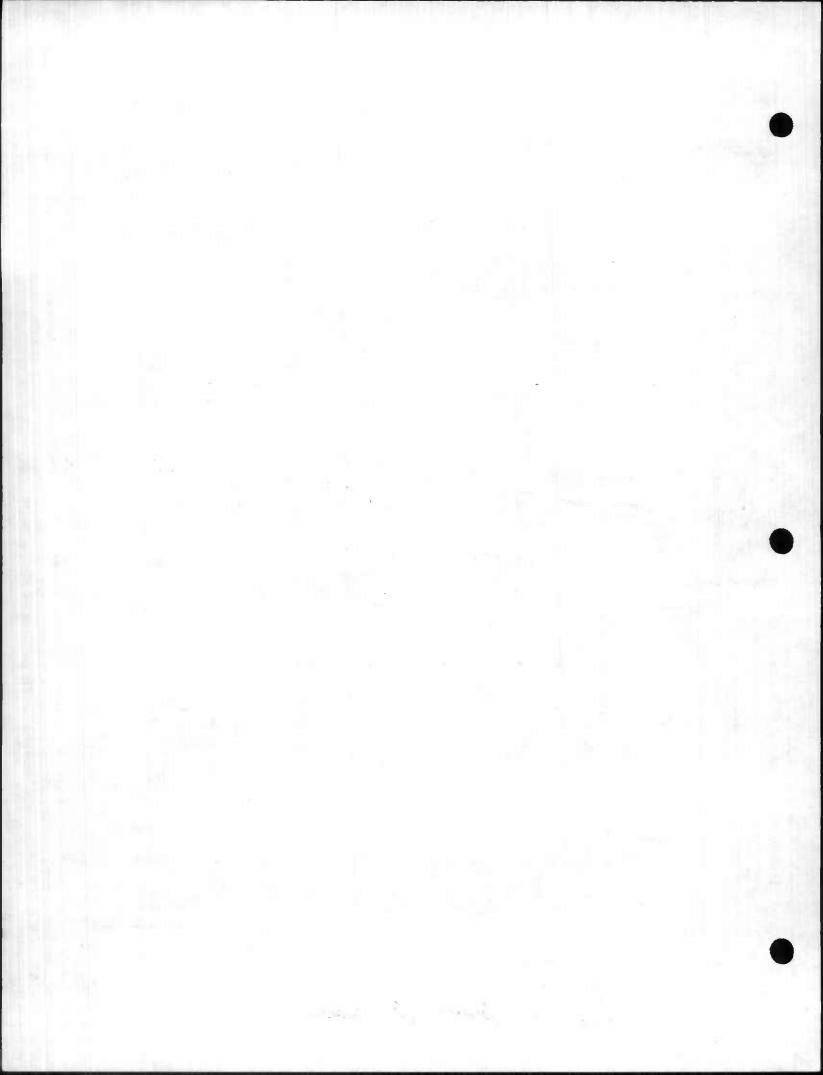
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Frances markel Tanuary 1999 7.222 31 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Medical System Bathmar Aga (In yrs. last birthday) Il Under 1 Year Il Under 24 Hrs. Months Deys Hours Min. of Maryland Baltmare University 6. Sax 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) **Funeral** Hours 1 M 2 XF Yrs. 67 Director 5 1931 216 28 1850 MARYLAND Usual Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yas 2 No Director BALTIMORE 250-1 ROSEDALE 10e Street and Number 10g, Citizen of What Country? 10f. Zip Code "natural", or hems 23s or 6615 A GOLDEN RING ROAD 21237 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas?

1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 XNo Specify: WHITE Specify: à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahouid be filed w Department of Health and Mantal Hygien Important: If them 27 is marriand other thu any Injury or other traumatic evant the HOMEMAKER OWN HOME 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be GIAMBATTISTA VARALLO MARY GRANDE 19a. Interment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6615 A GOLDEN RING ROAD BALTIMORE, MD 21237 DEBORAH SCHELHAUSE / DAUGHTER 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ⊠ Buriel 2 □ Crametion 3 □ Removal Irom Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2/4/99 GARDENS OF FAITH BALTIMORE, MARYLAND 21. Signature of Funeral Service Lighnsee 22. Nama and Addrass of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE, BALTO, 23a. Perf1. Enter the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete tnterval Between Onset end Death **Physician** /Medical Immediate Cause (Final exsangunation diseese or condition resulting in deeth) hours Examiner Examiner anthe hours ascending physician and the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): Box 68760. tension Physician/Medical Due to (or es e consequençe ot): disease (overan Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 ☐ Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy lindings evailable prior to completion of cause of death? ippe dar disease 24a. Wes en eutopsy performed? Completed 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28c. tnjury at Work? After 5 Pending investigation 1 Naturel within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, term, street, tactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and manner steted. To the Within 2 29b. Signetura and titla of certities 29c. License number 29d. Data signed (Month, Day, Year) D0050589 January 31, 1999 Monom 30. Name and address of person who completed causa ot death (Item 23a) (Type, Print) 22 S. Greene St Bultimor MD 21201 Cynthia D. Nelms umms MD 32. Registrer's Signeture 31. Dete tiled (Month, Dey, Year). 1999

Registrar

FEB 3



Item 4c Per PHY FilmG768 2-3-99

State of Maryland / Department of Health and Mental Hygiene

Division of Vital Records, P.O. Box 68760,		Baltimore, Maryland 21215-0020
within 24 hours effect death. To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	hysicia /Medic xamin	Department of Health and Montal Hygiana. Important: If them 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic avant, the Montal Earning must be notified as

Funeral

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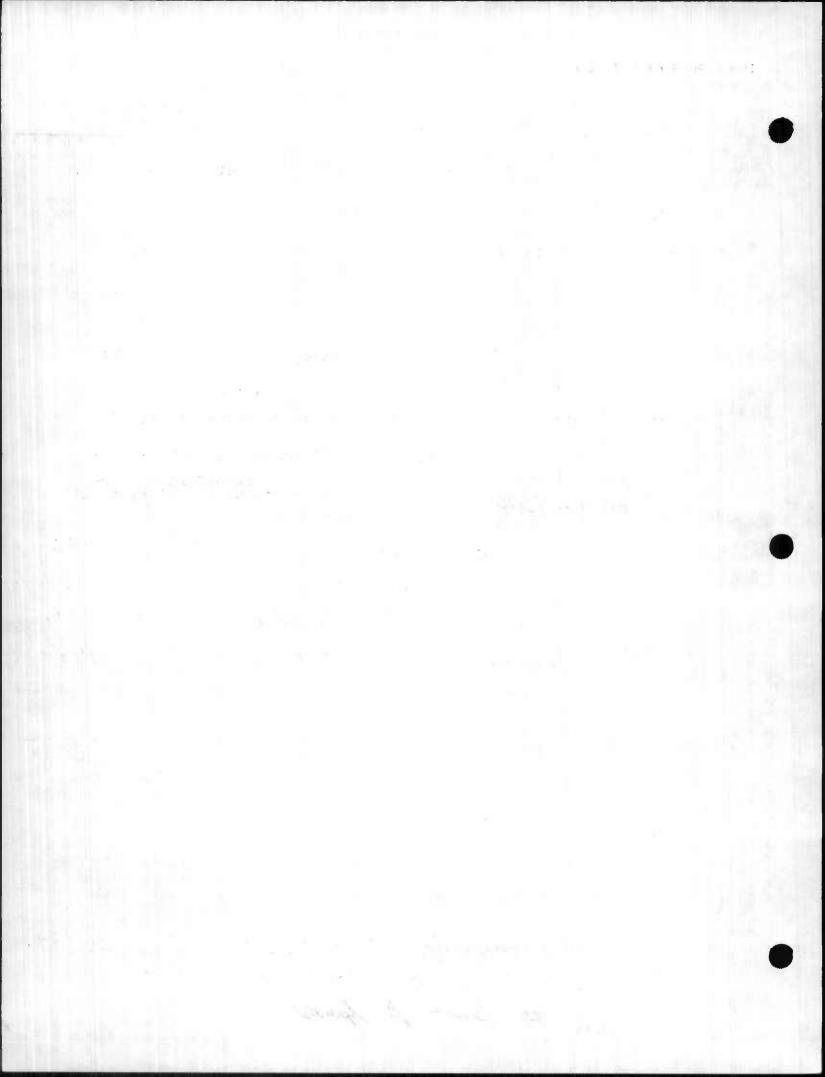
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Certificate of Death 4b. City, Town, or Location of Deeth 4c. Cond.

Bay 7 7 M 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15:21 **Physician** AGALENE /Medical Eacility Name (If not Institution, give street and number), Examiner Bal TIMORE BALTIMORE CIT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Pay, OCT 19 Birthplece (State or Foreign Country)
 MD 5. Sociel Security Number Pay Year 1938 1□M 2X F 60 unknown Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md N/A Balto 1XXes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6638 Collingdale Rd U.S.A. 21234 Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes ②☐No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondery (0-12) College (1-4or 5+) 10th N/A unemployed N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) William Tyler Virgie Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Tyra McKnight 1011 Halstead Rd Balto, Md 21234 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State Voshell Mem Gardens 2-3-99 Balto, Md 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility Betts Funeral HOme 1129 N. Caroline st Balot, Md 21213 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. SEPSIS Immediate Ceuse (Finel disease or condition resulting in death) PNEUMONIA Sequentially list conditions, if any, teading to immediate ceuse. Enter Underlying Cause (Disease or Injury HEART FAILURE Physician/Medical that initieted events resulting in death) Last RANTAL BLEED Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 70 28d. Describe how Injury occurred 27. Manner of Death 28b Time of 28c. Injury et Work? Certification: 1 Matural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

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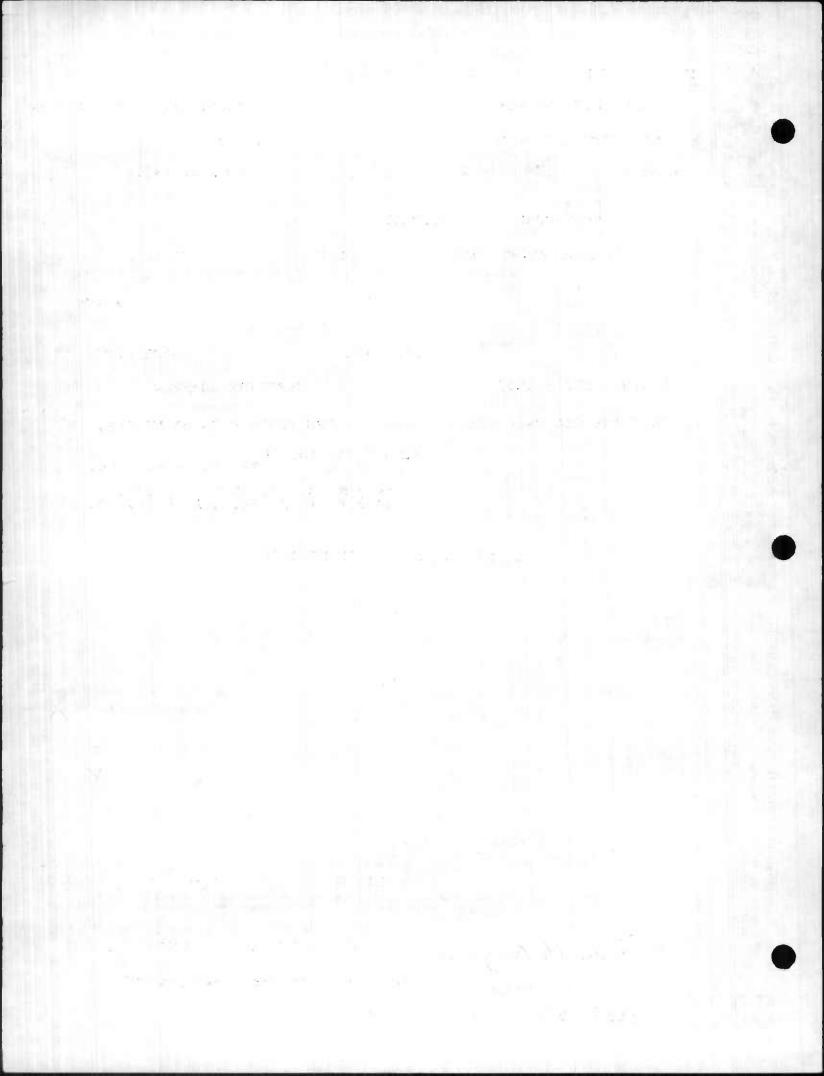
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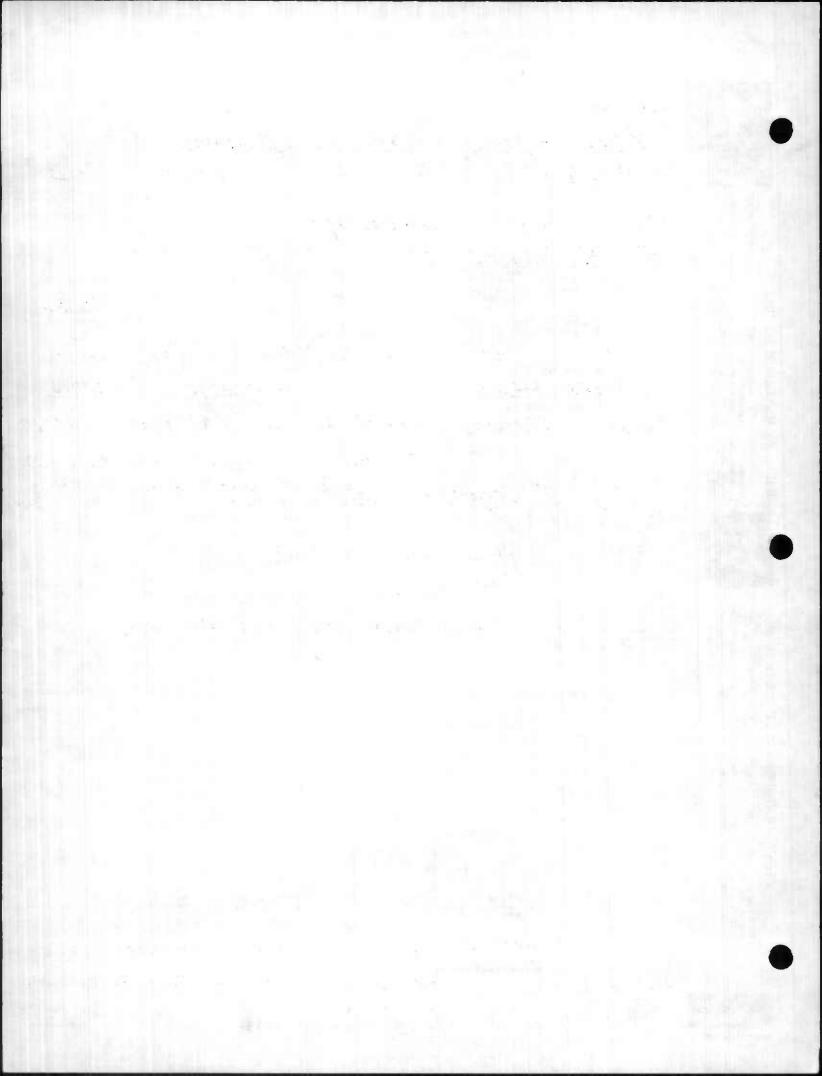


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 28 1999 Month **Physician** January 7:10 PM Brian Mealy /Medical 4b. City, Town, or Location of Death 4a Facility Nampa (If not institution, give street and number) 4c. County of Death Examiner 5. Social Sacurity Numb 9. Birthplaca (Stata or Foraign 7. Age (In yrs. lest birthday) **Funeral** 10 M 20 F Min Deys Hours 218-64-1577 Usuel Residance of Dacedant Yrs. Director with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director MORRE 10e. Street and Number 10g. Citizan of What Country? 8 permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or frems 23s any Injury or other traumatic event, the Hodical Examera. Funeral Was Decedant of Hispenic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14 Rece - American Indian 11. Marital Status Black, White, etc. Yas 2 No f Yas, Give Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: by 3 Widowed 4 Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middla, Last) Be 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Code) etimore, 40 2/2/7 aver 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 2100 MI. Lansdowne MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetura of Funeral Sarvica Licensing 22. Nama and Address of Facility
AUSTRY 23a Part Enter the disease, or complications that causad the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. . MD2121 Approximate Intervat Batween Onset and Death Physician /Medical Immediata Causa (Final disaesa or condition rasulting in daath) Examiner by Physician/Medical Examiner attending physician end for use as the buriel-transit certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury thet Initieted avants rasulting in daath) Last MANUMODEFICIENCY Box 68760 Due to (or as a consaquanca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No 24b. Wara autopsy findings available prior to 24a. Was en eutopsy performed? Completed peen completion of cause of death? page 2 has 1 Yas 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was casa rafarrad to medical exeminar? 26. Pleca of Daath (Chack only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 1 A Inpatient 1 TYas 250 No 2 ER/Outpatient 3 DOA After this funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarmined 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 6 4 Homicida filled in 154 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data end placa, and dua to tha causa(s) and mannar as atated.

2 Medicat Examiner: On the basis of axamination end/or invastigation, in my opinion, daeth occurred at the time, dete end place, end due to the cause(s) and mannar statad. 29a. Cartifiar within 24 hor To the Fune completely fi Medicai (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of cartifiar 29c. License number 30. Nama and addrass of person who complated causa of daeth (Item 23e) (Type, Print) 2000 WEST BALTIMORE STREET BALTIMORE MARY LAND VICTOR

State Registrar 31. Date filed (Month, Day, Year)

32. Ragistrar's Signature



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

CAXHEVINE MAT3 dovf January A Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW S. Social Security Number S. Social Security Number A Security Number JOHNS HOPKINS BAYVIEW S. Social Security Number A Security Number JOHNS HOPKINS BAYVIEW S. Social Security Number JOHNS HOPKINS BAYVIEW JUNGET 1 Year JOHNS HOPKINS BAYVIEW S. Date of Birth (Month, Day, Year) JOHNS HOPKINS BAYVIEW JOHNS HOPKINS BAYVIEW S. Social Security Number JOHNS HOPKINS BAYVIEW JOHNS HOPKINS HOPKINS BAYVIEW JOHNS HOPKINS BAYVIEW JOHNS HOPKINS HOPKINS BAYVIEW JOHNS HOPKINS HOPKINS HOPKINS HOPKINS HOPKINS HOPKINS HO		Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of									
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Top State 10b. County BALTIMORE 10d. City Town or Location MD. N/A BALTIMORE 10d. Zip Code 1118 S. ROBINSON STREET 10d. Zip Code 11224 U.S.A. 118 S. ROBINSON STREET 120 State U.S.A. 118 S. ROBINSON STREET 120 State U.S.A. 118 S. ROBINSON STREET 120 State U.S.A. 118 S. ROBINSON STREET U.S.A. 118 U.S.A. 118 S. ROBINSON STREET U.S.A. 118 U.S.A. 118 S. ROBINSON STREET U.S.A. 118 U.S.A. 118 U.S.A. 118 S. ROBINSON STREET U.S.A. 118 U.S.A	ner	JOHNS HOPKINS BAY 5. Social Security Number 219–18–6592	VIEW 7. Age (In yrs	N N	Under 1 Year	BALTIM If Under 24 Hrs	ORE 8. Date of Bir	h y, Year)	A 9. Birtho	lace (State or Foreight) LAND	
The Street and Number 107 Zip Code 109_Citizen of Whet Country? 1.5			10c. C	ity, Town or Locati	ion				1	0d. Inside City Limit	
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15. Decedent's Education General Conditions G			N CTDEET			2.4				itry?	
15. Becodent's Education 15. Becodent's Educ		11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in tarmed Forces? 1 Yes 2 1 No If Yes, Give	If Ye	s Decedent of H es, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No rto Rican, etc.)	- 14. Ra	ce - Americ ack, White,	etc.	
SAMUEL MARSHALL SAUNDERS 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MALTER M. MOROZ, SR. / SON 118 S. ROBINSON STREET, BALTIMORE, MARYLAND 21224 20a. Method of Disposition (Name of Cemetary, cramshory or other place) 1 Buriel z Xix remains and Removal from State of Disposition (Name of Cemetary, cramshory or other place) 2 Disposition (Name of Cemetary, Cramshory or other place) 2 Supera and Address of Eachilly 2 Supera and Address of Facility 3 Supera and Address of Facility 4 Supera and Address of Facility 4		(Specify only highest grade	completed)			eation duning most of wo d)	orking		Business/Ind	dustry	
19b. Malling Address (Street and Number or Flural Route Number. City or Town, State, Zip Code) MALTER M. MOROZ, SR. / SON 118 S. ROBINSON STREET, BALTIMORE, MARYLAND 21224 20b. Method of Disposition Date 2\text{Air-mation} 2\text{Deposition} 2D			ALIAID #20.0						me)		
WALTER M. MOROZ, SR./SON 20b. Method of Disposition 1 □ Durie 1 2 Morenston 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funcal Service Licensee 22. Name and Address of Facility 21. Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches only one cause on each line. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches the disease. Or one cause on each line. 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches the disease. Or one each line. 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches the death of Double of the death Do				10h Malling /	Addraga (Stead				Ctate 7in	Code	
Tool S. CONKLING STREET, BALTIMORE, MD. 21224 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feiture. It is only one dause on each line. Approximate shock, or heart feiture. It is only one dause on each line. Approximate shock, or heart feiture. Approximate shock or heart feitu		20a. Method of Disposition 1 ☐ Buriel 2 All Fremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b. GR	Place of Disposition Commenterry, crement EENMOUNT 22. N	on (Name of ony or other plea CEMETE ame and Addre LY & ZE	ce) RY 2/ ss of Facility ILER INC	2/99 . FUNERA	BALTIMO	- City or To	wn, State	
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death January 29, 199999:00 A.M Month Dav **Physician** PAUL OMREGCIK /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Kosedale tranklin Square Hospital Cer 7. Ada (In yrs. last birthday) enter | Inday | If Undar 1 Year if Under 24 Hrs. 8. Data of Birth (Month, Day Year) Feb. 9 1929 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax **Funeral** Months Days 12 M 2□ F 233-40-4202 69 Director WestVirginia Usual Rasidence of Dacedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Md. Baltimore Essex 1 Yes 2X No Director 10g. Citizan of Whet Country? 10e. Street and Number 10f. Zip Coda 1000 Franklin Ave. 21221 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 11. Maritel Status 1 Yas 2 2No If Yas, Giva Year or Dates: 1 Navar Married 2 Married White 1 ☐ Yas 2 XNo Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry al Hygiane. Eiementary/Secondary (0-12) Collega (1-4or 5+) American Standard Bath Tub Ename ler 10th M rescik 17. Fathar's Neme (First, Middla, Last) 18. Mothar's Name (First, Middle, Malden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 Is marked oth any lolury or other traumatic even page. Be Mary Hirscarvich Frank Omregcik 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1521 Williams Ave. Baltimore Md. 21221 Frank Omregcik / son 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 X Cramation 3 ☐ Removal from Stata Metro Crematory Inc. 1/30/99 Baltimore Md. 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 23e. Part1. Enter the disease, or complications that causad the doubt. Do not antar tha mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one causa on each line. Approximete Intarvai Between Onset and Deeth **Physician** 3 Hours /Medical Immediata Causa (Final diseese or condition rasulting in death) **Examiner** Examiner ardiovascular Disease Hrteriosclerotic (physicien and the burial-trensit certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disease or injury that initialed avents rasulting in death) Lest Physician/Medical Dua to (or as a consaguance of) ettanding p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed by t Disorder þ 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed erebrovascular Accident cartificata hes lirector, paga 2 s 2 No 1 ☐ Yas 2 ☐ No 1 Yas Division of Vital Attending Physician: 25. Was casa rafarrad to medical Be 26. Piaca of Death (Check only ona) axaminer's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Aftar 1 Naturel 5 Panding invastigation injury al or Attending s after death. 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be 28e. Piece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. Madical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and menner stated. Medicai 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signeture end title of certifier esos

State Registrar

Malika Wascem 32. Registrar's Signatura 31. Data filed (Month, Day, Year) 3 1999 FEB

30. Neme and addrass of person who complated causa of deeth (Item 23a) (Type, Print)

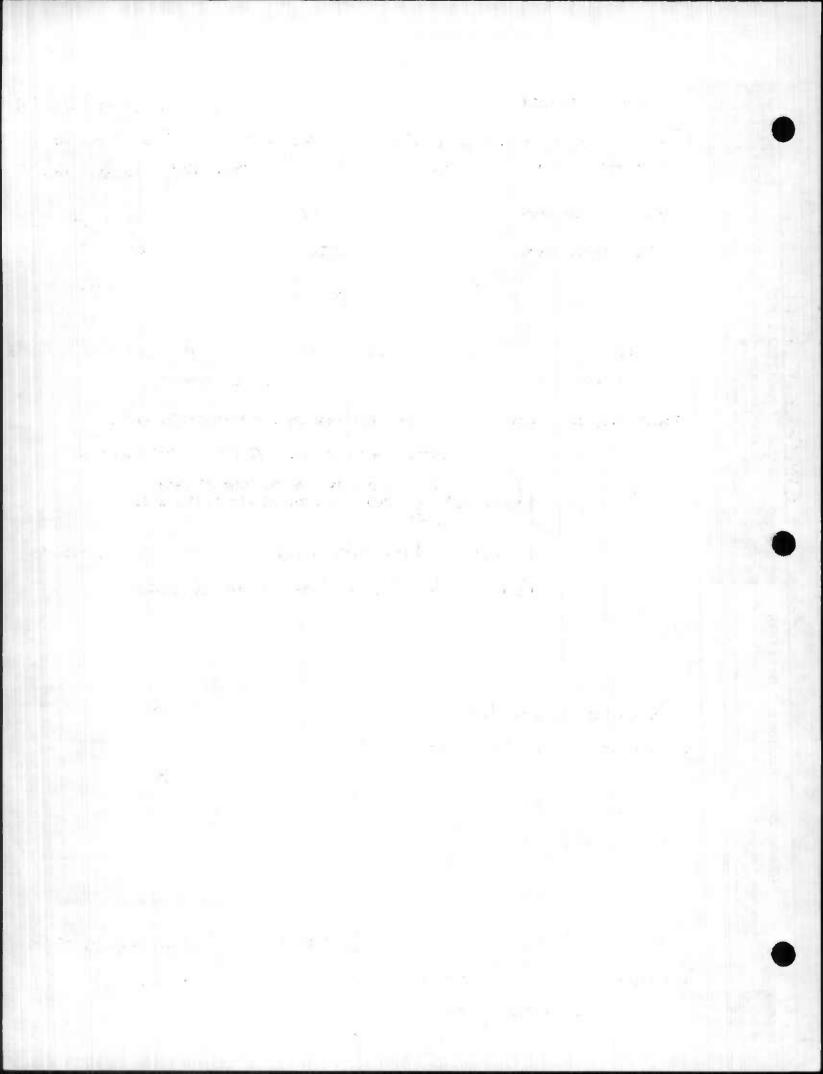
9000 Franklin Square Drive Baltimore, MD 21237

38754

January 29, 1999

DHMH 16 Rev 6/95

Paul



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death JANUARY 28 1999 5:05F TTO 4a Fecility Name (If not institution, give street and number) Holy Cross Nursing Home 4c. County of Deeth Montgomery County 4b. City, Town, or Location of Deeth Burtonsville 7. Age (In yrs lest birthday) If Under 1 Yeer Months Days Date of Birth (Month, Day, Year) July 27, 1920 5. Social Security Number 387 1 M 2 F Birthpleca (State or Foreign Country) West VIrginia Months Deys Hours Yrs. Usuel Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Burtonsville 10g. Citizen of Whet Country? U.S.A. 10e. Street and Number 3420 Forsythia Lane 10f. Zip Code 20866 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14 Rece - American Indien Bleck, White, etc. 1 Never Married 2 Merried White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) newspaper Elementary/Secondary (0-12) College (1-4or 5+) advertising department secretary 17. Fether's Neme (First, Middle, Last) Everett Andrew Hoffman 18. Mother's Neme (First, Middle, Meiden Sumame) Grace Higgins 19a. Informent's Name/Reletionship (Type, Print) Ms. Jan Otto Tannen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3420 Forsythia Lane Burtonsville, MD 20866 Daughter 20b. Pleca of Disposition (Neme of cometery, crematory or other place) Columbia Memorial Park 20c. Location - City or Town, State 20e. Method of Disposition Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 01/29/99 Columbia, Maryland 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funerel Service Licenses MO0533 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) · Chronic Obstructure Luxa YEALS Due to (or es e consequence of): STOKING Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown CAMCEN OF LUNGS 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 1 No 1 Yes 25. Wes case referred to medicat exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending investigation 2 No 1 Yes 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be axecuted or Attending Physician: Hospital

attending physicien and for use es the burial-transit Division of Vital Records, P.O. Box 68760, signed by the a d be detached f irector, page 2 s this funeral eftar deeth Director:

Physician

/Medical

Examiner

Director

Funeral

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marked other than "natural", or itema 23a or 28a-f sho matic event, the Modical Examiner must be notified as

permit. Pages 1 and 2 should be filed within 72 hours after death with 10 Department of Health end Mental Hygiena. In Important: If Item 27 is marked other than "natural", or Itema 23a or 21 any Injury or other traumatic event, the Medical Exercises or 21 once.

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29a. Certifier

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29b. Signature and tifle of pertific

Baltimore, Maryland 21215-0020

the Maryland

1 24 hours efter to Funeral Direct pletely filled in b To the To To the Complet

> State Registrar

BRITHER. ALLEN 31. Dete filed (Month, Day, Year) 1000 MD 12201 32. Registrer's Signeture

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

PLUM discHARD

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner as steted

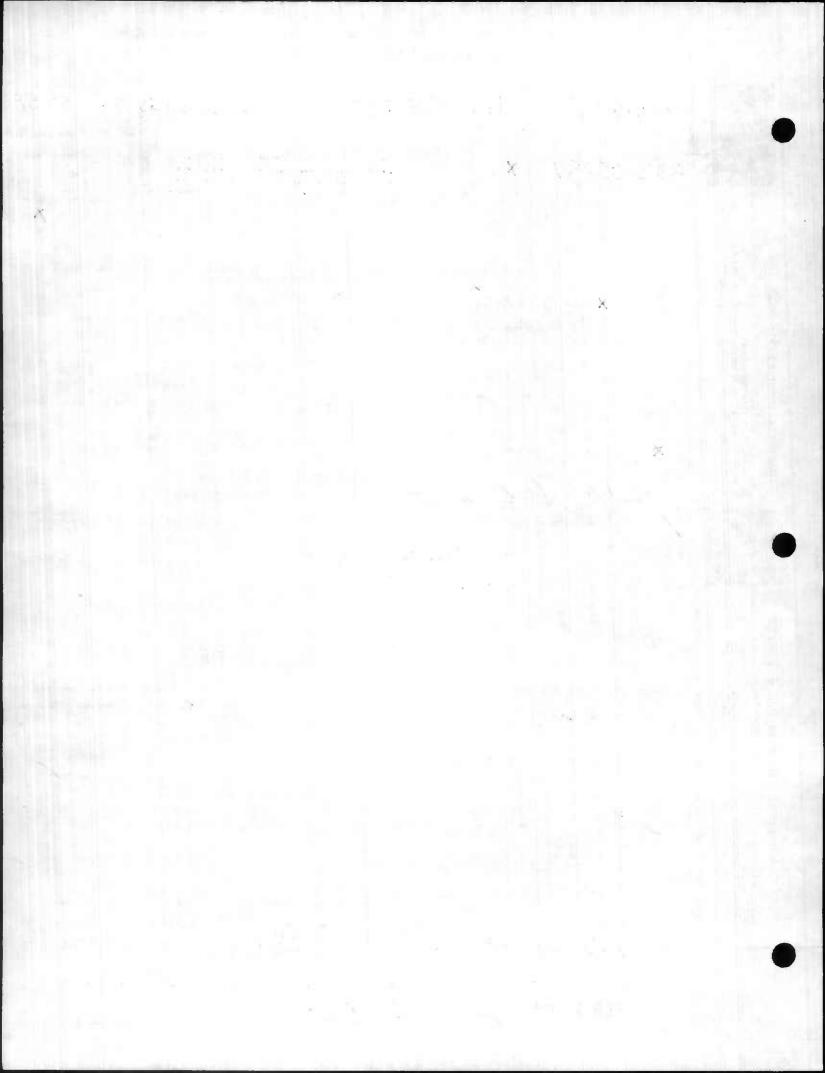
2 Medical Examinar: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

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29d. Date signed (Month, Day, Year)

SILVER SPRING.

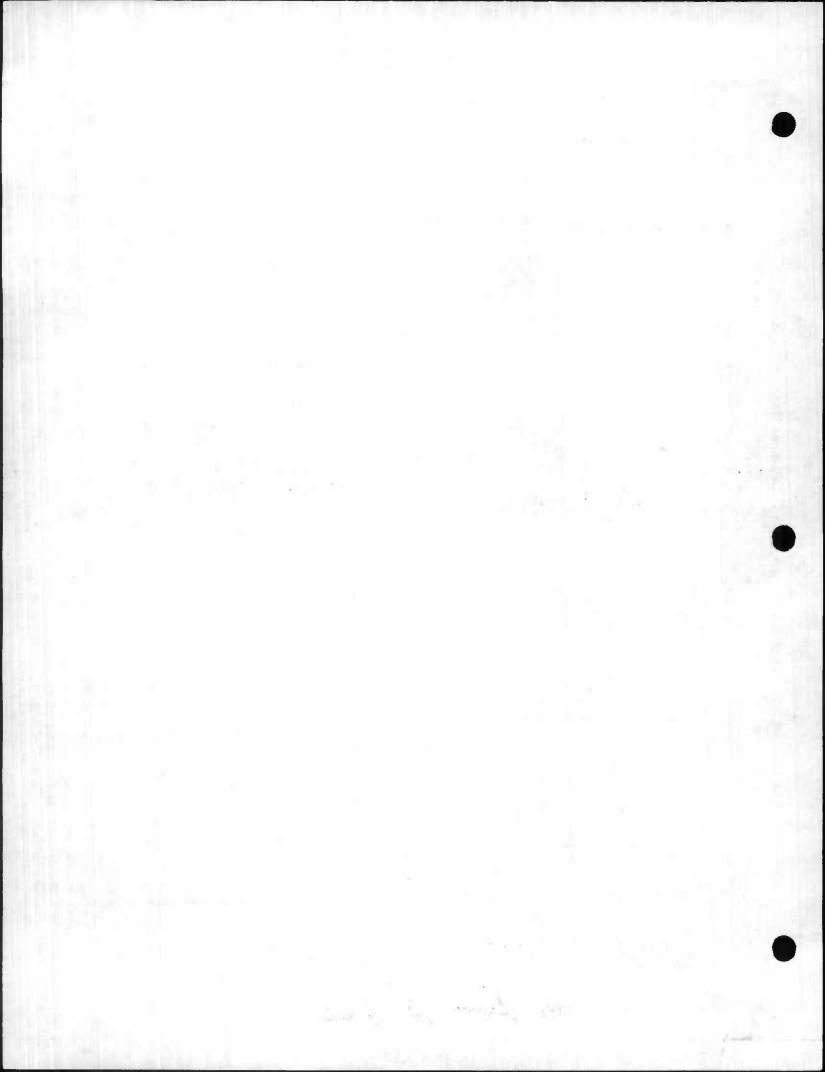


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 11: 10 AM **Physician** Platt 30 Michael JANUER Y 1999 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MAryland Hospital BAltimorE N/A If Under 1 Year | If Under 24 Hrs. 5. Scalel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Funeral Months Hours 128 M 2□ F Director Mar. 9.1957 220-74-1256 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location t0d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 □ Yes 2 50 No Director Maryland Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 237 Candlelight Way 21061 U.S.A.

14. Rece - American Indian,
Bleck, White, etc. death Funeral Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. p 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If frem 27 is marked other that any injury or other traumatic event, that once. 12 N/A Machinist M&D Machine 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Matthew W. Platt, Jr. Beatrice Cuffley M. 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mark Platt (Brother) 8396 Armstrong St. Pasadena, Maryland 21122 20b. Plece of Disposition (Name of cemetery, cremetery or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Mem. Park 2/3/99 Elkridge, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 Collina 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel Hepatocellular YEARS diseese or condition resulting in deeth) Examiner Examiner physician and the buriel-transit that the death certificate be assouted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yaa 2 No 3 Probably 4 Unknown -IVER à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? peed 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funara Certification: Netural 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner stated. edical 29e. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier JANULTY 1999 m.o. 30 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 22 South Greene Street Gregory Springett
31. Date filed (Month, Day, Péar) University Maryland Ball: more mo. 21201 m. D. 32. Registrer's Signeture State FEB 3 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: #5 PER F.H. G768 2-5-99 WR. Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6:54 P.M. **Physician** Olga Ostrowski Januar /Medical 4b. City, Town, or Location of Dee 4a Facility Name (If not institution, give street end number, 4c. County of Death Examiner Franklin Square Hospital Center Rosedale If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 215-12-4559 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M X F Days 75 **Director** Feb. 10,1923 | Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Dunda1k Baltimore 2 10e. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? 7 is marked other than "natural", or itema 23a or traumatic event, the Medical Examiner must be a 21222 1946 Inverton Road United States Funeral 14. Rece - American Indian, 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: by 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene, Elementary/Secondary (0-12) Coilege (1-4or 5+) Factory Worker Brewery 8 Years 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle, Maiden Sumame) Be Ignatius Kurlik Mary Komorowski 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a H Item 27 In 2802 Creston Road Dundalk, Maryland Carolyn Leader/Niece 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removal trom State Gardens of Faith Cem. 2/3/1999 4 □ Donation 5 □ Other (Specify) Rossville, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Between Onset and Death 23a. Part1. Enter the discher shock, or heart failure. **Physician** Myocardial Infarction 2 Hours Immediate Cause (Final disease or condition resulting in death) Aviedical Examiner Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): SE USB 23b. Did tobacco usa contribute to the cause of death? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart 2 No 3 Probably 4 Unknown 1 Yes g 24b. Were eutopsy tindings available prior to 24a. Wes an autopsy performed? Completed Bleading Gastrolntostinal completion of cause of death? has 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: funeral director, 25. Was case reterred to medical exagniner? 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death
1 ANatural
2 Accident 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending after death. Director: Aft 1 TYes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the ceuse(s) end manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number January 30,

STROWSKY, Olga

31. Date tiled (Month, Dey, Year)

30. Name and address of person who dempleted cause of death (Item 23a) (Type, Print).

Or. Grace Tang, 600 Franklin Square Drive, Baltimore, Maryland 32. Registrar's Signature

DHMH 16 Ray 6/95

Registrar

and other of suggest on the " 8 48 4 6 3 8 ALCHE CARREST CATALON CONTRACTOR OF THE STATE OF THE STAT Section of the second of the s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) ROGERS 1600 Hrs JANUARY 27 1995 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) BALTIMORE RALTIMORE NORTHWEST HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Days 86 Yrs. 218-07-1664 1. M 2□ F AUGUST 09,1912 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits WYes 2 No BALTIMORE MARYLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code PLACE, APT. *6 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA. 12. Wes Decedent Ever In U.S. Armed Forces? 1 X Yes 2 No // - /4-43 14. Reca - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify BLACK 3 Widowed 4 □ Divorced Year or Dates: 02 - 20-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7+4GRADE FINISHER DOUG WESLE) 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) ROGERS GARFIELD CATHERINE 19a. Informent's Name Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 5 LIBERTY PLACE APT 6 BALTIMORE, MD. 21244 lace of Disposition (Name of Date 20c. Location - City or Town, State ANNETTE EVANS (DAUGHTER) 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST CEMETERIOZ-03-99 OWINGS MILLS, 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSE PH H. BROWN JR. FUNERAL HOME 2140 N. FULTONAVE, BALTIHORE, MO. 21217 of Funeral Service Library BROWN JR. FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEU MONIA disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of) Pert II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Part i 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy

Physician /Medical Examiner

certificate be executed

Division of Vital

Hospital or Attending

within 24 hours of To the Funeral I

Physician

/Medical

Examiner

10e. Stete

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at

ie marked other than

permit. Peges 1 and 2 should be file Department of Health and Mental Hyy Important: If frem 27 ie marked othe any Injury or other treumatic event, phose.

Funeral Director

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death with the Meryland

Baltimore, Maryland 21215-0020

ettending physician end for use as the buriel-trensit the signed by the been s certificate hes nours efter death.

neral Director: After this or
y filled in by the funeral dire Physician/Medical Examiner

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Completed

To Be

Certification:

Medical

1 ☐ Yes 2 🐼 No 1 Yes 2 TNo 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2/2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

29b. Signeture end title of cartifier

29c. License number

29d. Date signed (Month, Day, Year) JANUARY 27, 1858

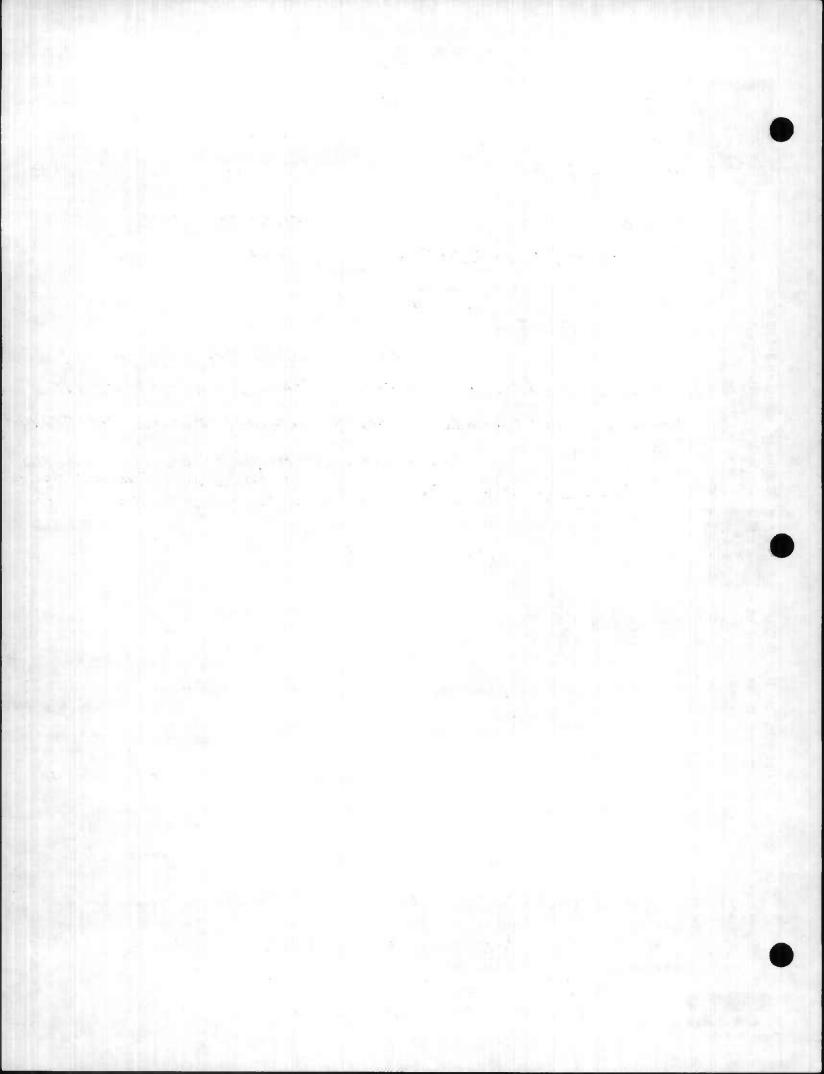
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

BALTO. MD NHC MP

State Registrar

31. Date filed (Month, Day, Year)

32. Register's Signature



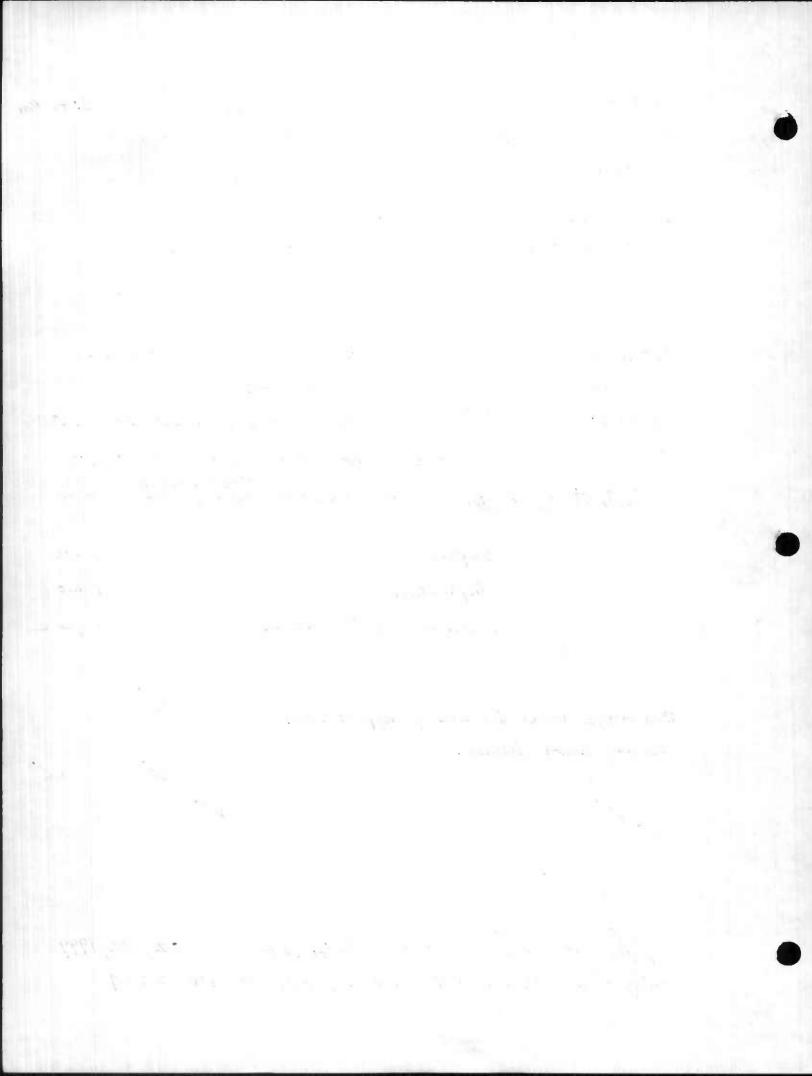
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** James Edward Redd January 28, 1999 /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 812 Mockingbird Lane Apt. 201 Baltimore Baltimore 7. Age (In yrs. lest birthday) if Under 1 Year If Under 24 Hrs. 5. Sociei Security Number 8. Date of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) Deys 1€M 2□ F 216-01-0165 78 Yrs. Director July 24, 1920 Md. Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md. Baltimore Baltimore 1 Tyes 25 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 812 Mockingbird Lane Apt. 201 21286 USA Herns 23a Funeral 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, spacify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 Never Married 2 Married No Yes 2 No if Yes, Give Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☐ No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 limporant: if Itan 27 is marked other than "netulenty injury or other traumatic event mentions." 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Crane Follower Bethlehem Steel 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Roy Deerfoot Mabel Redd 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) wife Georgie Redd 812 Mockingbird Lane Apt. 201 Baltimore, Md. 21286 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Garrison Forest Veterans Feb. 3 Owings Mills, Md. 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signeture of Funeral Service Licenses 2501 Gwynns Falls PKWY Baltimore, Md. 21216 utter 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medicai Immediete Ceuse (Final Sepsis WK disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Aspiration that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest pue physician er s the buriel-t Box 68760, Multi-intarct Dementia Physician/Medical Pert II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 Unknown End stage renal disease, hypertention n signed i Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Be Completed 24e. Wes en eutopsy performed? ischemic heart disease 1 □ Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physicien:
 24 hours effer death.
 Funerel Director: Affer this certificately filled in by the funeral director. 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 1 DNatural 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funerel Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) 29a. Certifier Medicai 29b. Signature and tire of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 02,02,1999 D 46907 MD dress of person was completed cause of deeth (Item 23e) (Type, Print) 5601 Loch Raven Blud, Baltimore MD Lim

Registrar **DHMH 16 Rev 6/95**

State

31. Dete filed (Month, Day, Year)

32. Regultrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

EDWARD WALTER

State of Maryland / Department of Health and Mental Hygiene ITEMS: #23 PART I, 27 PER MEO G768 2-11-99 WR. Certificate of Death 3. Time of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Daath Month **Physician JANUARY** Edward W. Rosu 31, 1999 3:10 PM. '- /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Nama (If not institution, giva street end number) **Examiner** 18335 LOST KNIFE CIRCLE APT.101 Montgomery GAITHERSBURG If Undar 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthpleca (State or Foreign
Country) **Funeral** Months Days Hours Min 1**X** M 2□ F Yrs. 33 1965 Hawaii Director 56-62-3594 Usuel Rasidanca of Decedant with the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County 7.13 marked other than "natural", or items 23a or 28a-f ahow traumstic avent, the Medical Examiner must be notified at 1 Yas 2 XNo Director Maryland Gaithersburg Montgomery 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 18335 Lost Knife Circle Apt. 101 20879 United States death Funeral 12. Was Dacedent Ever in U.S. Armed Forcas? 14. Rece - Amarican Indian, Bleck, Whita, atc. Wes Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 2 should be filed within 72 hours after and Mental Hyglene.
Is marked other than "natural", or the 1 ☐ Yes 2 🖔 No If Yas, Giva 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White þ lf Yas, Giva Year or Dates: 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education (Spacify only highast grada complated) Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 4 Sales Computer 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be Dolores Agnes Quinn 10 George M. Rosu 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is m any injury or other traun pnce. P.O. Box 51 Richwood, New Jersey 08074 Dolores A. Gorman / Mother 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition Dete 20c. Location - City or Town, State 1X Burial 2 □ Cramation 3 □ Ramoval from Stata 2/3/99 Glasboro, New Jersey 4 ☐ Donation 5 ☐ Othar (Specify) Manahath Cemetery 21. Signature of Funaral Service Licensee Timothy Harman Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Balto., MD 21214 23a. Part1. Enter the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate intervel Betw Onset and Deeth **Physician** Immediata Causa (Final disaasa or condition resulting in daeth) /Medical SEIZURE DISORDER Examiner Due to (or es a consequance of): Examiner attending physician and for use as the burial-transit certificate be executed Saquantially list conditions, if any, laading to immadiata cause. Entar Undartying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Due to (or es a consequance of): Box 68760 Physician/Medical Dua to (or as a consequence of): P.0. Part II. Other significent conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 170 signed by ti 1 Yes 22 No 3 Probably 4 Unknown by of Vital Records, 24b. Wara autopsy tindings eveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed peen certificate has 1. Ves 2 No 1 X Yes 2 □ No 25. Was casa referred to medical axeminar? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Homa 5 X Rasidenca 8 □Othar (Specify) s after death.

I Director: After this or 1 XYas 2 No 2 funeral 28d. Dascribe how Injury occurred 27. Mannar of Daath 28a. Date of injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? Certification: Division 5 Panding 1 X Natural 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 2 4 Homicida To the Hospital o within 24 hours at To the Funeral D 29a. Cartifian 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, end due to tha ceuse(s) end mannar es statad. Medical 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the lime, deta and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) O.C.M.E. FEB. 01, 1999 311

111 Penn Street, Baltimore, Maryland 21201

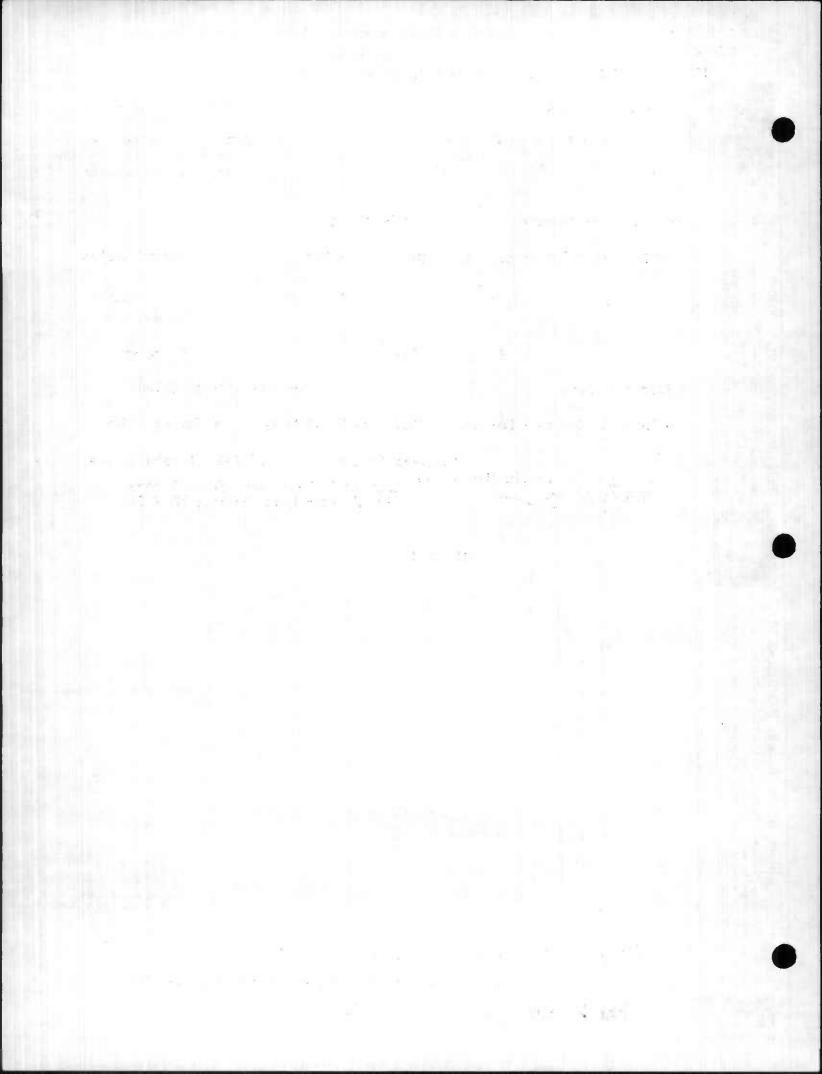
State Registrar

Stephen

30. Nama and addrass of person who completed cause of deeth (Item 234) (Type, Print)

Radentz

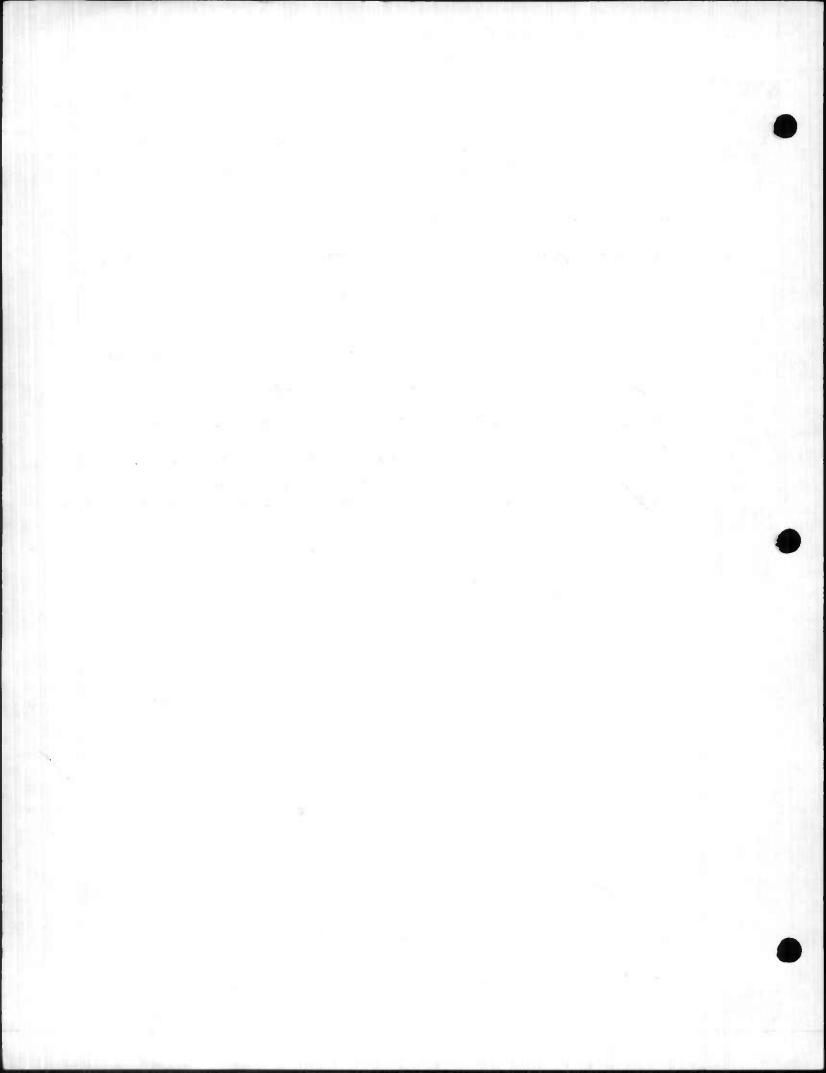
32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

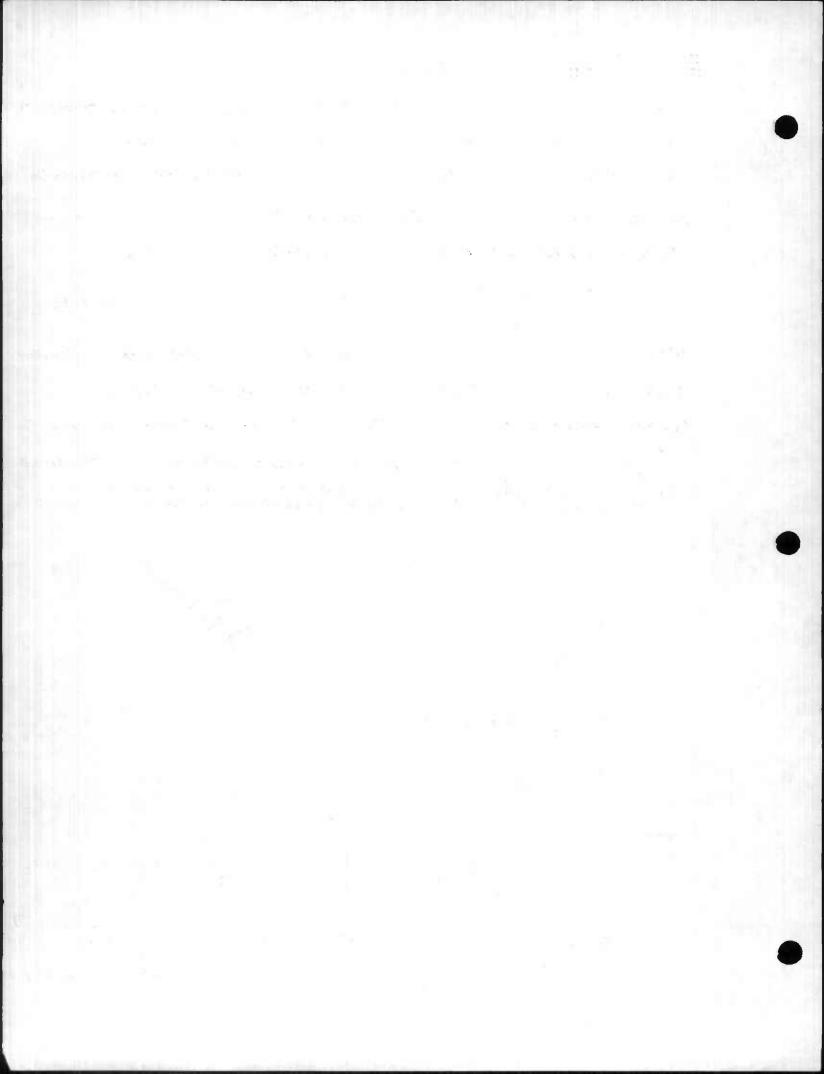
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(Check only 2 Medical Exami	y sician: To tha best ilnar: On tha basis o	t of my knowle	edge, deeth occur n and/or Investige	red at tha time	e, dete end piece,	end due to tha d	causa(s) end ma	anner es stata	d. a causa(s)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ITEMS: #28A-F PER MEO 768 State of Maryland / Department of Health and Mental Hygiene ITEMS: #3, 23 PART II, 27 PER MEO G768 2-4-99 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 33Tinge of Death Day **Physician** SMALLWOOD SR WILBERT WARREN JANUARY 26, 1999 9:00 A.M /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 1823 PARK AVENUE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 MM 2 □ F 43 214-64-0812 Director JAN. 29, 1955 MARYLAND Usual Residence of Decedent Marylend 10c. City, Town or Location 10a. State 10b. County rai', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits BALTIMORE 1 Yes 2 No MARYLAND Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVENIUE 1823 11. Marital Status 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 25 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK p 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry should be filed within 7, and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 10TH GRADE MOYER HARID MOVING COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 12 should be fill h and Mental H Is marked oth RUBERT SMALLWOOD SR. JOSEPHINE (HN-UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 Department of Health s Important: If item 27 is any injury or other tra (WIFE) 935 DANTREY COURT, BALTIMORE, MD 21225 LORNA SMALLWOOD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) 4 | Donation MT. ZION CEMETERY DZ-DI-99 LANSDOWNE, MARYLAND 21. Signature of Fig. 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pue burial-tran Due to (or as a consequence of): physician of the burial Box 68760 Physician/Medicai Due to (or as a consequence of): 950 Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown signed by 1 | Yes 2 | No Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 2 Accident 5 Pending or Attandin efter death. Director: Aft UNKNOWN 1 Yes 2 No Investigation UNKNOWN UNKNOWN M 6 X Could not be determined 28f. Location (Street and Number or Rural Route Number AVE . City or Town, State) FOUND: 1823 PARK AVE . 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide FOUND: HOME BALTIMORE MD. Hospital 24 hours 29a. Certifier factorifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29b. Signature and title of cartifier 7743472 EUTAW CLACE, BALTIMONE 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PETER CHIMA G.MD 24 25 31. Date filed (Month, Day, Year) 32. Redistra Signature State 3 1999 ▶ FEB Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	State of Maryland	d / Department of Health and	Mental Hygiene
Item 10e Per FH FilmG76		Certificate of Death	Reg. No.

giene	9	9	0	2	7	1	5
Reg. No.							

Physician /Medical Examiner

Funeral Director

with the Meryland death

item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Examiner must be notified at Director 3606 Wabash Ave 740 Poplar Grove St., Apt. 11L 21215 Funerai 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dalas: permit. Pages 1 and 2 should be filed within 72 hours after 1 begament of Heelih and Mental Hyglene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinat 1 Naver Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ◯NO Specify: 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) UNKNOWN N/A State Hospital Worker 17. Fether's Name (First, Middla, Last) Albert Stewart 2 19e. Informent's Name/Raletionship (Type, Print) Francis Webb/daughterinlaw 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20a. Method of Disposition 1 Deurlei 2 Cremation 3 Removel from Stete Arbutus Mem Pk 4 ☐ Donetlon 5 ☐ Other (Specify) Hecia **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician and the bunal-transit certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medicai Dua to (or es e consequence of) 80 USB for Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. he signed by alcoholism hronic Division of Vital Records, þ Completed certificate hes il or Attending Physician: efter death. I Director: Atter this certifica 25. Was cese referred to medical examiner? Be Hospital: XXYes 2□ No 0 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: 1 Naturel 5 Pending Invastigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Atterwithin 24 hours efter dea To the Funeral Director completely filled in by the 28e. Plece of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the besis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner stated. (Check only one) 29b. Signeture end title of certifian 29c. Licansa number O.C.M.E.

1. Decedent's Neme (First, Middla, Last) 2. Dete of Death 3. Time of Death Month Felton Stewart 23, 1999 9:51 A.M. January 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore

| H Under 1 Yaar | H Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year)
| Davs | Hours | Min. | A pril 5, 740 Poplar Grove St., Apartment 11L Birthplace (State or Foreign Country)
 GA 5. Social Security Number 6 Sax 7. Age (In yrs. lest birthdey) 15M 20 F Months 89 133-01-9920 1910 Usuel Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTO 1 Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A. Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - Amarican Indien, Bleck, White, etc. Specify: BLACK 16b. Kind of Business/Industry Hospital 18. Mother's Neme (First, Middle, Meiden Sumema) Emma Ferrell 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 3606 Wabash Ave Balto, Md 21215 20c. Location - City or Town, Stete 1-29-99 Balto, Md 22. Name end Address of Facility Betts Funeral HOme 1129 N. Caroline st Balto, Md 21213 23a. Part1. Enter the disease, or complications thei ceused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth a Atheroscleratic Cardiovascular disease 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Ware eutopsy findings availeble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Limited 12 Yes 2 □ No 1 DYas 2□ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year) January 24, 1999

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

5. Radentz 111 Penn Street, Baltimore, Maryland 21201 phen 31. Dete filed (Month, Day, Year)

State Registrar

1999 FEB 3

32. Regisker's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Smith 11:17 A Deanetre 30 January /Medical 4b. City, Town, or Location of Death 010 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Pandallstown Hospital Center Northrest COUNT ROOM Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1□M 2√ Yrs. 213-28-5048 83 Director May MD Usual Residence of Decedent with the Maryland r 28a-f show 10e. Stete 10b. County 10c. City. Town or Location 10d, Inside City Limits 1XXes 2□No MD N/A BALTO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be a 8405 Allenswood Rd permit. Pages 1 and 2 should be filed within 72 hours efter death v. Department of Health end Mental Hygiena. Important: If flem 27 is marked other than "natural", or flems 23a page in July or other treumatic event, the Medical Example matter. 21133 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Hospital Housekeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown Hattie Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Name/Reletionship (Type, Print) Henrietta Jupiter 8405 Allenswood Rd Balto, Md 21133 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-4-99 Balto, Md Arbutus Mem Pk 4 Donation 5 Other (Specify) 22. Name and Address of Facility Betts Funeral Home 21. Signature of Funeral Service Licenses 1129 N. Caroline St Balto, Md 21213 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximete tnterval Between Onset and Deeth **Physician** Sepsis /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner Source tection law requires that the death certificate be asscuted attanding physician and for use es the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical that initiated events resulting in deeth) Last Due to (or as a consequence of): 80 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? ed by the a signed by t 1 Yee 2 No 3 Probably 4 Unknown Congestive Heart Failne 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy Diabetes peeu has The 2 No 1 Yes 1 Yes 2 No certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) 1□Yes 2D No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Naturel 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifiq 29c. License number

Center 5401 Old Carr Road Randall Stown, MD

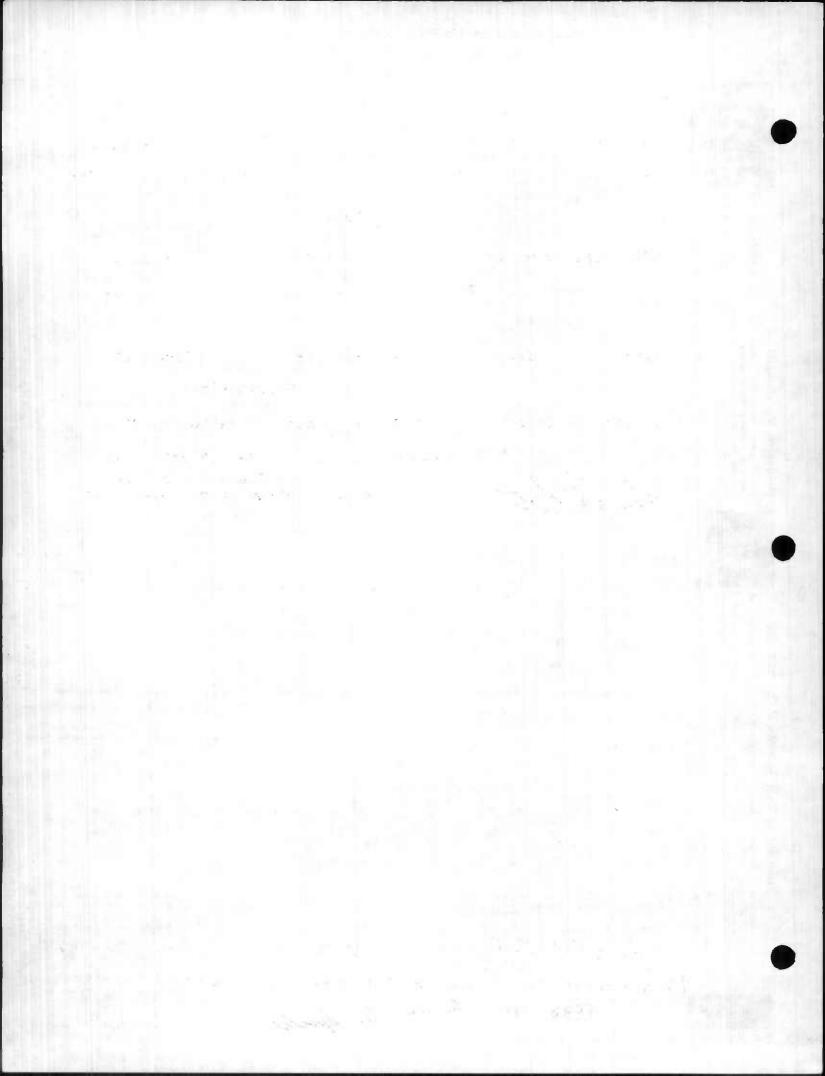
State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northwest Hospital

1999 Registrar's Signeture

Knorf

31. Dete filed (Month, Day, Ybar)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month mitt 2:10 999 Am 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not Institution, give street end number) Care If Under 1 Year | If Under 24 Hrs. | 8. Da Janor 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, Year) 1-23/9 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex Days 1 M 2 F Months Hours Min 219-10-7656 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Md NA MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 Avenue MEGGE loania 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Black Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Manager 11th grade NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) effries Maggie Jeffnis 19b. Malling Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ga 30340 Atlanta 1119 Can Daughter VIVIAN 0 FOW 9 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3 rus Mem. 2 4 ☐ Donation 5 ☐ Othar (Specify) Tar of Funeral Service Licensee 22. Name and Address of Fecility 2/2/5 Parch F. H. West 23a. Part. Enter the albease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each tine. Avenue Approximate Intarval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) 20montia Due to (or as a consequanca of): Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 200 25. Was cese referred to medical examiner? 26. Place of Daath (Check only one) Other: 1 ☐ Yes 4 SolursIng Home 5 ☐ Rasidence 6 ☐ Other (Specify) 25000 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner The law requires that the death certificate be executed

important: If it any injury or o

Physician

/Medical

Examiner

10a. State

60

Director

Funeral

þ

Completed

Be

2

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow

Baltimore, Maryland 21215-0020

?? is marked other than "natural", or Hema 23a or 28a-f ahow treumatic avent, the Naulcal Examinar must be notified at

Physician/Medical Examiner by Completed Be To Certification:

ettending physician end for use as the burial-transit signed by the e hes certificate director, After this funeral à Funeral Dire

Division of Vital Records, P.O. Box 68760,

or Attanding Physician:

efter death.

Hospital 24 hours edicai within 24 hox To the Fune completely fi State

29a. Certifian (Check only one) 29b. Signature and title of certifier

Natural

2 Accident

3 ☐ Sulcide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated.

5 ☐ Pending

Investigation

6 Could not be determined

MO

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

29c. License number

1 Certifying Phystelan: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to the ceuse(s) and mannar as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 1999

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Ralt mare

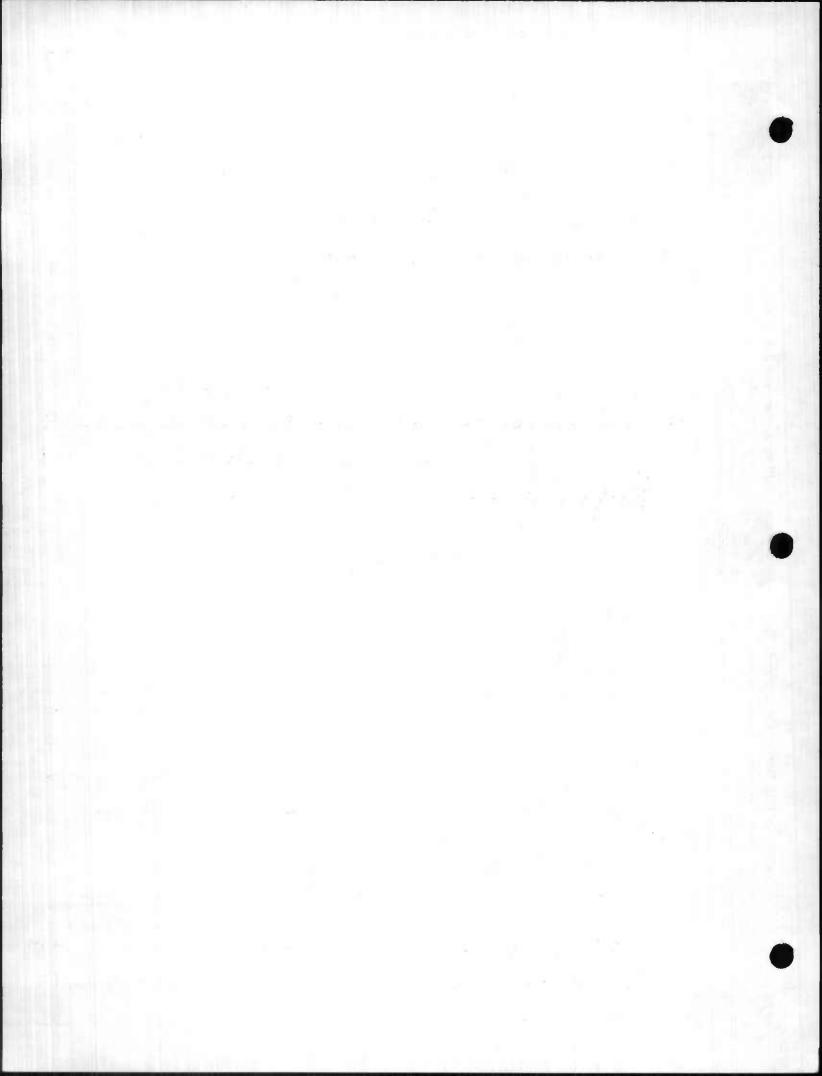
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

222

31. Date filed (Month, Day, Year)

32. Pagistrar's Signature

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician WITLITAM** THOMAS SMALL January 1999 . 45 an /Medical 4c. County of Deaf 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** oseda Franklin Square If Under 1 Year Montha Deys 10 more HOS p.ta Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 127 2□ F Director 89 223-03-9005 SEPT 24 1909 NORTH CAPOLINA Usuel Residence of Deceden 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show 1 Yes 20No Director MARYLAND BALTIMORE **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Nerns 23s 909 HYDE PARK ROAD U.S.A. 21221 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 Tho
If Yes, Give
Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian 11. Merital Status Bleck, White, etc. 1 Never Married 2 Married "natural", or Specify: ELACK 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental thyglene. Important: if item 27 is marked other than ** any filury or other traumatic event, in a Heal and place. Elementery/Secondary (0-12) College (1-4or 5+) 3rd grade UTILITY MAN BETHLEM STEEL 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be HENRY SMALL EMMA SMALL 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JANIE B. SMALL/Wife 909 Hyde Park Road, Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1XMurial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) HOLLY HILLS MEMORIAL 2-2-99 MIDDLE RIVER, MARYLAND 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W. NORTH AVENUE 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) Cardiomyopathy stage years Examine Examiner certificate be axecuted physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? D.O. 1□ Yaa 20 No 3 Probably 4 Unknown mentia Records, À 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 2 NO 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d Describe how injury occurred 28b Time of 28c. Injury at Work? 1 Netural 5 Pending death. 1 Yea 2 No n 24 hours after death.

• Funeral Director: A pletely filled in by the fi investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and manner stated. (Check only one) To the I within 2. 29b. Signeture and title of certifier 29c. License number 29d. Date aigned (Month, Dey, Year) wordn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Savitha Shivananda 31. Date filed (Month, Day, Year) Drive Baltimore, MD 2/237

State Registrar

DHMH 16 Rav 6/95

ORIGINAL

Square

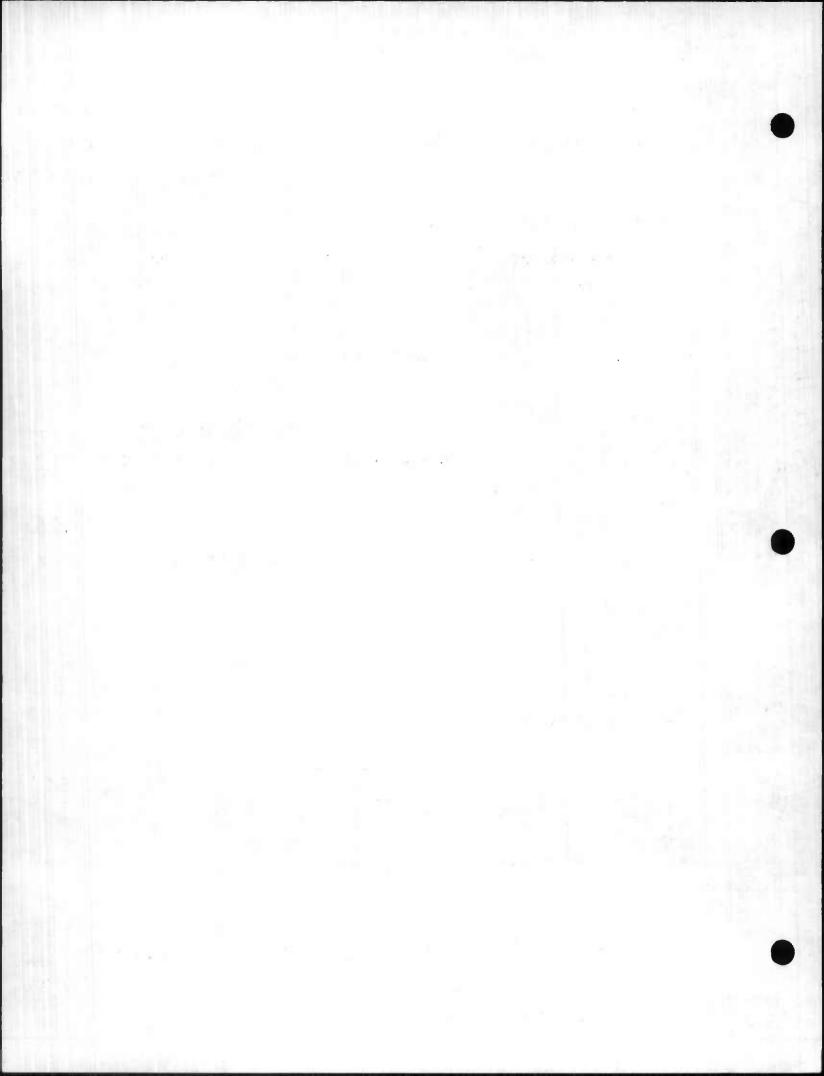
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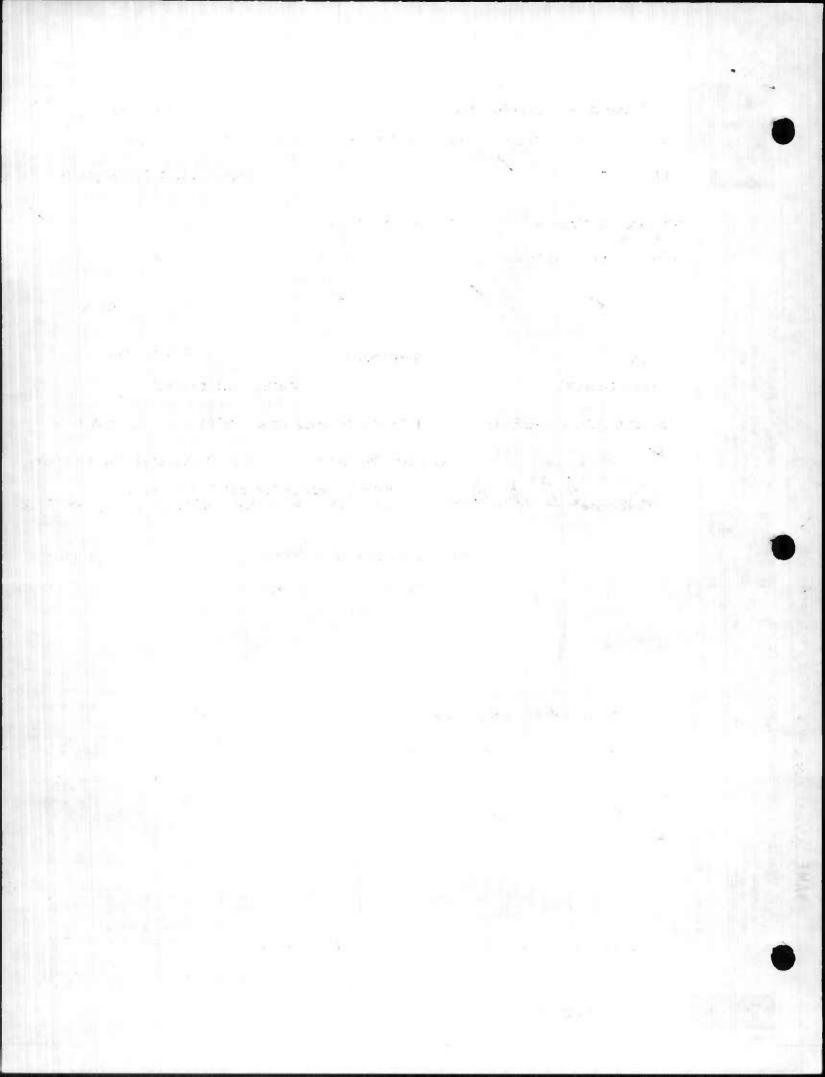
FEB

32. Registrar's Signature



	1. Decedent	's Name (First, Middle, L		2. Dete of Deeth Month Day Year 3. Time of Dea				of Death				
Physician / Medical	Josephine V. Slowikowski							Month Day Yes			8 0	MA
Examiner	4a Facility N	lame (If not institution, g					4b. City, Town, or		h 4c. County	of Death		
	ST.	Agnes 1	realth	Care -	900 Ca	ton Ave	Bati	more	N/	A		
Funeral Director			Sax 1 □ M 2 🗷 F	iga (In yrs. las 91	st birthday) Yrs.	If Under 1 Year Months Days		(Month, D	rth ay, <i>Year)</i> 18, 1907		oleca (State otry)	
		ence of Decedent						TALL CIT	10, 1501	TRAL	yıara	
a or 28a-f show the notified at Director	10a. State	10b. County		10c. City,	Town or Loca	ation				1	0d. Inside	
sta oto	Maryla	nd Baltimo	re	Edmo	ondson	Height	S				1 □ Ya	s 2 N
or 28e-f sh be notified.	10e. Street a	and Number				10f. Zip Code			10g. Citizen of V	What Cour	ntry?	
	1418	Forest Park	Avenue			2120	7		USA			
r Isama Riber m Fune		er Married 2 Married	12. Was Decedent Armed Forcas 1 Yes 2 H	?	lf '	as Decedent of Yes, specify Cub	Hispanic Origin? (S pan, Maxican, Puerl Specify:	pecify Yes or No o Ricen, atc.)		ck, White,	etc.	
Exar d by		owed 4 M Divorced	Year or Dates:								White	
ygiene. Nr. the Medical. Completed		15. Decedent's E (Specify only highest g.			(Giva k	nt's Usual Occu nd of work dona	during most of wo	rking	16b. Kind of B	usiness/Inc	dustry	
Pan Pan	Elementar	y/Secondary (0-12)	College (1-4or	5+)		O NOT use retire	9d)		Restara	unt		
		h Nama (First, Middla, Las	11		Waitr	ess	18 Mother's Nar	ne /First Middle	, Maiden Suman			
arked off attc ever To Be	TODA	ph Sawicki	.,							10)		
To Tatlo		-	/Time Print		10h Mailine	Address /Chros		ha Maliszewski				
Health and N lam 27 is me other traums		19a. Informant's Name/Relationship (Type, Print) Dolores Kuhn / Daughter 19b. Mailing Address (Street and Number 1418 Forest Park Av						ral Route Number, City or Town, State, Zip Code)				
Healt Im 2 Iher		of Disposition	20h Plei			raik Ave.	Date	imore, Md. 21207 20c. Location - City or Town, State Sykesville, Mary				
5 2	1 Sur	ial 2 Cremation 3		e cen	Ob. Place of Disposition (Name of cemetery, crematory or other place)							
spartment sportant: I sy injury o		4 Donation 5 Other (Specify) Lakeview Cemetery 21. Signature of Funeral Sarvica Licaured 22. Name and Address of Facility						2/2/99	Sykesvi	ille,	Mary	Tand
xaminer	resulting In	death)	a.	Due to (or a	CO P	enca of): Dexa	cerbo ti	on		1	30	
attending physician end I for use as the burial-transit Clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequence of): Due to (or as a consequence of):											
tending physicians use as the buse as the buse an/Medical	resulting in	death) Last	d	Due to (or a	s a consequ	enca of):						
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signed by the at ld be detached for d by Physici	Part II. Other	Myo Cord			_		iven in Part I.		Yes 2□ No			
ate has been page 2 shou		Myocordial inforction Congestive Heart failure						24a. Wa	Nas an autopsy enformed? 24b. Ware autopsy finding available prior to completion of causa of death?			
								1 🗆	Yes 2 No	1[☐Yes 2	No
	25. Was cas	25. Was case referred to medical 28. Place o					28. Place of De	eath (Check only one)			1	
his certific Il director, To Be	examine 1 Yes	17	Hospital:	tient 2□FI	R/Outpatient	3 DOA O	Other:			er (Specil	(v)	
After this funeral of		of Death			8b. Time of	28c. inju		28d. Describe how injury occurred		37		
th. After fune tion	1 Natu						ork? □ Yas 2 □ No					
Etc E	3 ☐ Suic 4 ☐ Hon	cide 6 Could not	28e. Placa of Ir building, e	njury - At hom etc. (Specify)	e, farm, stre	et, factory, office		28f. Location City or To	(Street and Numb own, State)	ber or Run	al Routa M	um <i>ber,</i>
within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a, Certifie (Check one)	1 Certifying P	hysician: To the best miner: On the basis and manner s	of examinatio	edge, death n and/or inve	occurred at the tostigation, in my	ime, date and place opinion, death occu	a, and due to the urred at the time	cause(s) and man, date and placa,	anner as s end due te	itated. o the cause	e(s)
ompl	29b. Signatu	ra and title of certifiar				29c. Licen	se number		29d. Data signe	d (Month,	Day, Year)
> 1- 0		sumi khe	ii MD			P	11703		Jan.	29.	199	9
2		nd address of person who		death (Item 2	(3a) (Type. P	rint)				2.01		
9	SU. Name an	address of person who	· completed cause of	Death (Item 2	I loal L	4 CUAD	- 900	caton	Ave - 1	salt.	mal	R

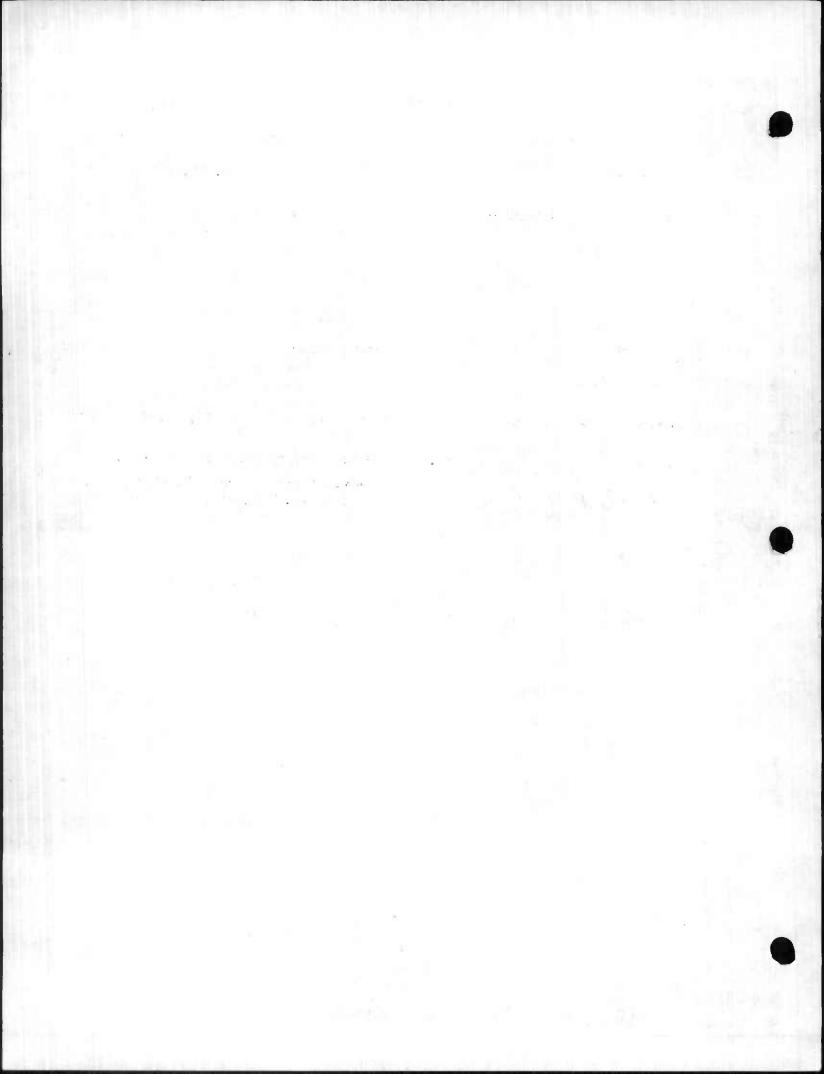
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Sliwa 10:30AM Mary Frances January 31, 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Dundalk 6855 Boston Avenue If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🖾 F Director Dec. 13,1915 Maryland 83 215-05-9021 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County show 1 TYes 2 No Dundalk Baltimore Director Maryland 288-4 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 6855 Boston Avenue United States 21222 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1₺ Never Merried 2 Merried 1 ☐ Yes 2X No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Year or Detes: Specify: à 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondery (0-12) 8 Years College (1-4or 5+) Western Electric Manufacturing d 2 should be filed w th and Mental Hyger 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Pages 1 and 2 ahould be Department of Health and Mental Important: If Item 27 is market any injury or Be Andrew Sliwa Sophie Pieko 19e. Informant's Neme/Reletionship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2786 Moorgate Road Dundalk, Maryland Andrea Bowers Niece 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Deta 20c. Location - City or Town, Stete ₩ Buriei 2 Cremetion 3 Removel from State Stanislaus Cemetery 2/3/1999 Dundalk, Maryland 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses Dundalk, Maryland 23a. Petri. Enter the disease, or complications that caused the deeth, shock, or heer tailura. List only ona ceusa on each line. 7922 Wise Ave. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intarval Between Onset end Death **Physician** /Medical fmmediete Ceuse (Final CORDMARY ARTERY DISEASE diseese or condition resulting in deeth) Examiner THEROSCLEROTIC CARDIOVASCULAR Examiner attending physician and for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exacts) FIBRILLATION Box 68760 Physician/Medical thet initiated events resulting in death) Last Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of defth? Division of Vital Records, P.O. signed by t 3 □ Probably 4 □ Unknown 1 Yes 2 No à 24b. Wara autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yas 2 2 No 1 Yas 2 No certificate 25. Was case ratarrad to medical examiner? Be 26. Place of Deeth (Check only oge) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Masidence 6 Other (Specify) Certification: To this : After this funeral 28a. Dete of Injury (Month, Dey Year) 27. Manne of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera 1 Neturai 2 Accidant 5 Panding 1 Tas 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Plece of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated. edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) FEB 0 3 1999 Registrar

32. Registrer's Signeture



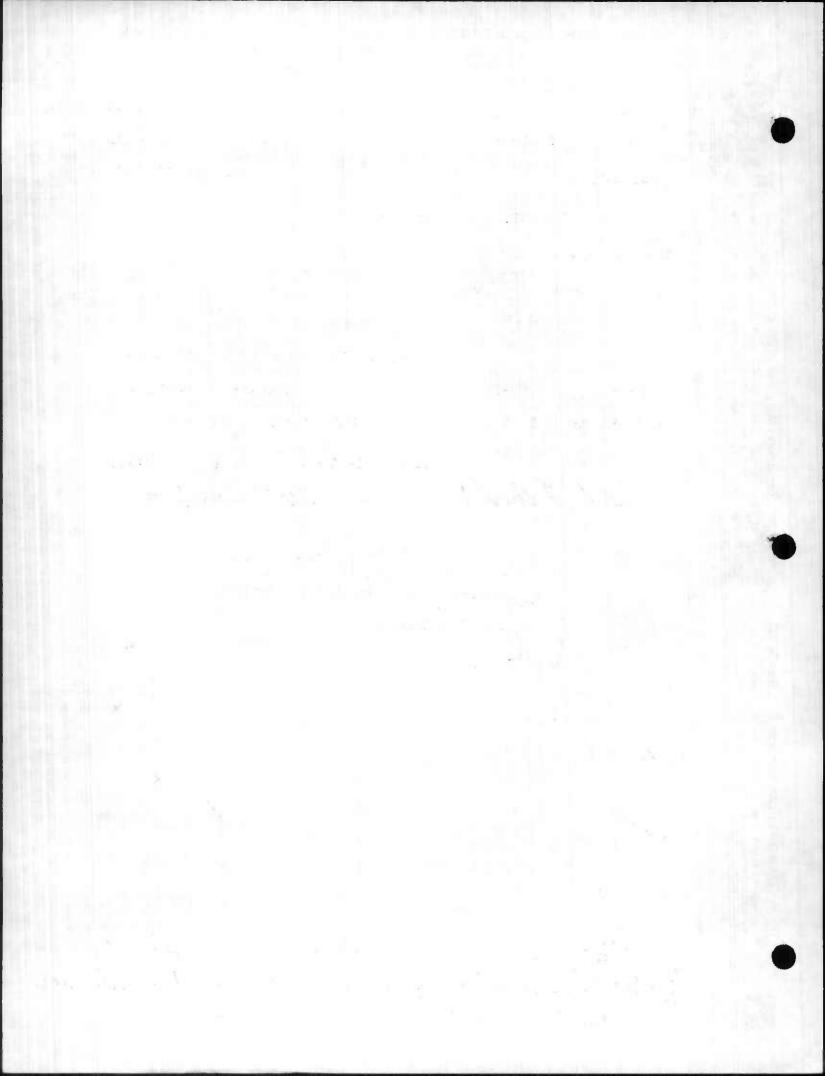
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) **Physician** 31,1999 JANUARY GORDON LEE THROWER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 488 HOLIDAY STREET ODENTON ANNE ARUNDEL 8. Date of Birth (Month, Day, Year) MAY 10, 1928 9. Birthplace (State or Foreign 5. Social Security Number Sex M 2□ F 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 70 Yrs. GEORGIA Director 416-36-0170 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 shownshy injury or other traumatic event, the Maryland 2002. 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No ODENTON MD ANNE ARUNDEL Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 488 HOLIDAY STREET 21113 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2X No Specify: WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) RESTAURANT 05 BARTENDER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) SHELL THROWER PEARLEY PARRISE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WILEY W. HORTON BROTHER 844 MARBLE CITY HEIGHT, SYLCAUGA AL. 35150 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 X Cramation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2-02 METRO CREMATORY BALTIMORE MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HARDESTY FUNERAL HOME P.A. 2 RIDGELY AVE ANNAPOLIS MD alro 12 23e. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Diseasa or injury that initiated events resulting in death) Lest Dua to (er as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequanca of): 980 signed by the a 23b. Did tobacco use contributa to the cause of death? Plant. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to should be 24a. Was an eutopsy performed? completion of cause of death? cartificate has b director, page 2 s 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 25. Was case raferred to medical examiner?
1 ☐ Yes 2 ☐ No director, Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 5 Pending 1 Tas investigation aftar death.
Director: A 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide a Funeral Di letely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examinar: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. within 2 To the 1 comple 29b. Signature as 29c. License number 29d. Date signed (Month, Day, Year) 0 who completed cause of death (Itam 23a) (Type, Print) 34 Date filed (Month, Day, 32. Registrar's Signatu State

DHMH 16 Rev 6/95

Registrar

3 1999

FEB



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Item 5 Per FH FilmG768 2-10-99 rja Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Name (First, Middla, Last) Day 955 **Physician** 1999 e 31 Januar /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner 6. Sex/ 1 M 2 □ F 8. Data of Birth (Month, Day 9. Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min Usual Rasidanca of Dacedant Director the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida Olty Limits x 28a-f show 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? "naturel", or items 23s or 12. Was Decedant Evar in U.S. Funeral 72 hours after death 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race -Amarican Indian, 11. Marital Status Armed Forcas Black, Whita, atc. Navar Marriad 2 Married 1 Yas 2 No Baltimore, Maryland 21215-0020 1 Yas 20 No Specify: þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation
(Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 7 is marked other than "nature traumatic event, the Medical 15. Decedant's Education (Specify only highast grada complated) und unic filed within un Collega (1-4or 5+) Elamantary/Secondary (0-12) Hygiene. 17. Father's Nama (First, Middla, Last) und 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Pages 1 end 2 should be nent of Heelth and Mental I Suardian 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2 /20/ 19a. Informant's Name/Ralationship (Typa, Print) Heelth a N. CATHEDRAL 1000 WANDA 37. BACTIMORE, MD or other 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Dala 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) 10N CEMETERY 21. Signalura of Funeral Corrice License 22. Nama and Addrass of Facility alber 638 N On not antar the mode of dying, such as cardiac or respiratory arrest, Euneta Approximate 121 Interval Between Onsat and Daath MORE, 23a. Part1. Enter the dividese, or complication, that caused the death, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner that the deeth certificate be executed physician end s the burial-transit Sequentially list conditions, if any, leading to Immediate causa. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last noe of): P.O. Box 68760, Physician/Medical Dua lo (o as a consequanca of) 60 ò 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part been signed by the should be deteched 1 Yes 2 No 3 Probably Unknown Records, þ 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed After this certificate hes funeral director, page 2 Division of Vital Was casa rafarred to medicat axaminar? 26. Placa of Death (Check only ona) Be Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Yas 20 No 1 Inpatiant 2 ER/Outpatient 3 DOA 2 28a. Dala of Injury (Month, Day Year) 27. Manner of Death

1 ☑ Naturat

2 ☐ Accidant Certification: 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Attanding 5 Panding Invastigation 1 Yas 2 No deeth. ofter deet Director; 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Ptace of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homictda ò filled in 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 29b. Signatura and titla of certifian 29c. Licensa number 29d. Data signad (Month, Day, Year) who complated causa of death (Itam 23a) (Type, Print) 30. Name and address of person Hafez Z
31. Data filed (Month, Day, Yaar) nee

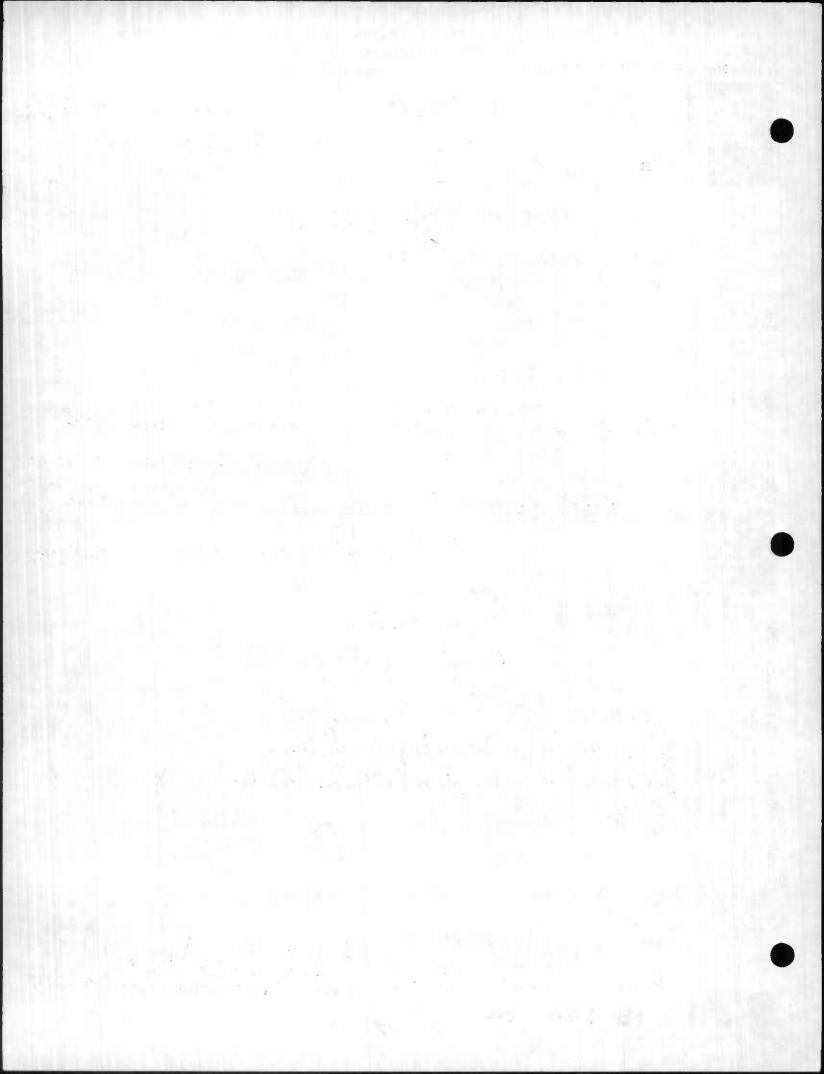
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DHMH 16 Rev 6/95

State

Registrar



State Registrar

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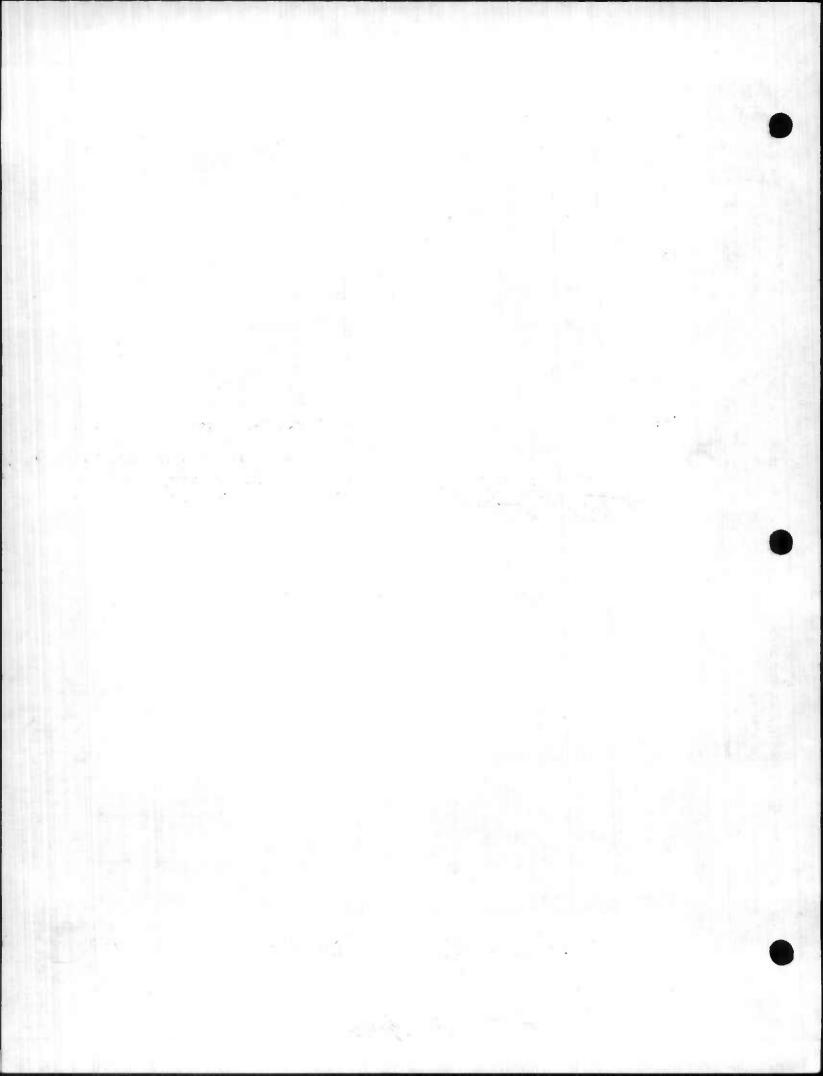
ORIGINAL

9000 FRANKlin SQUAREDR. BATTIMORE, MARYLAND 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

DR. William Stinne TTe 31. Date Had Month, Day, Year) FEB 3 1999



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 1999 Month **Physician** 11:50am Jan. 30 Charlotte E. Walsh /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Heritage Nursing Home Baltimore Baltimore If Under 24 Hrs. 8. Date of Birth Month, Day, July 30 If Under 1 Yeer 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 1928 **Funeral** Days Months 1 □ M 2X F July 70 Yrs. 219-22-7647 Maryland Director Usual Residence of Decedent the Meryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flams 23a or 28a-f show edical Examiner cust be notified at Md. Baltimore Essex 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3 Crafton Road 21221 USA Peges 1 and 2 should be filed within 72 hours after death neat of Health and Mental Hygiene.

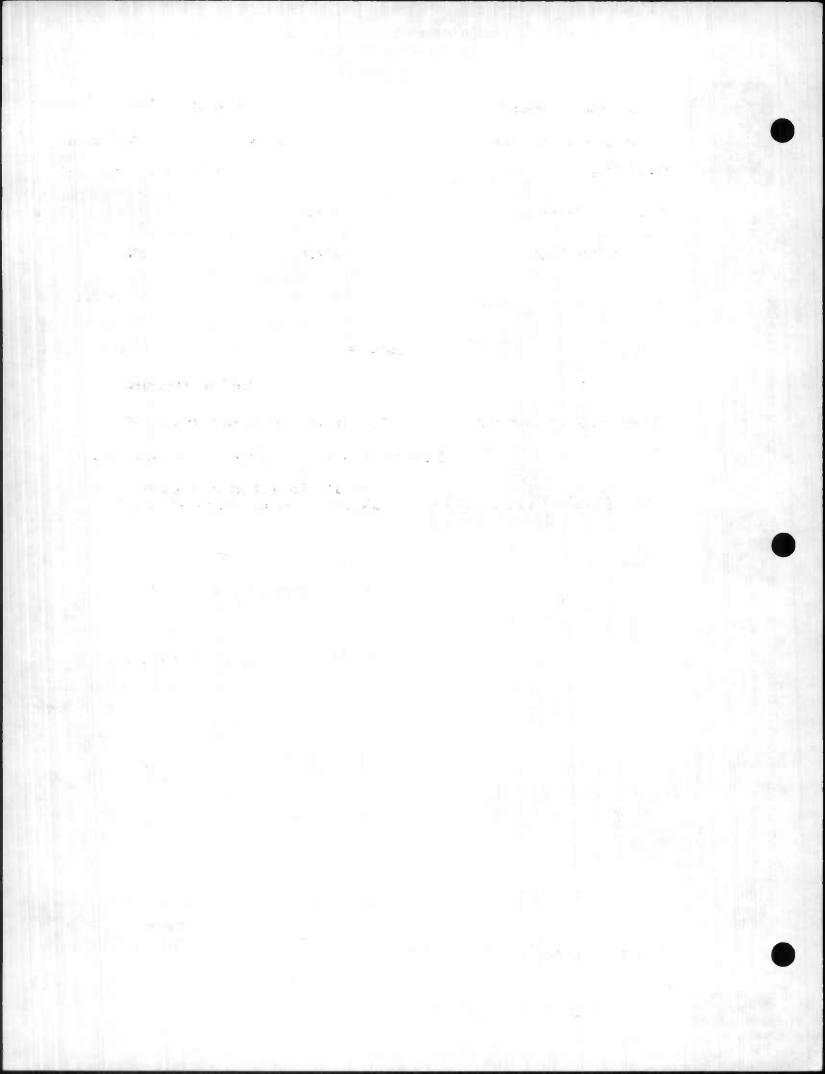
Ant: If them 27 is marked other than "naturat", or thema 23 ury or other traumatic event, it a feedical Experient traumatic. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

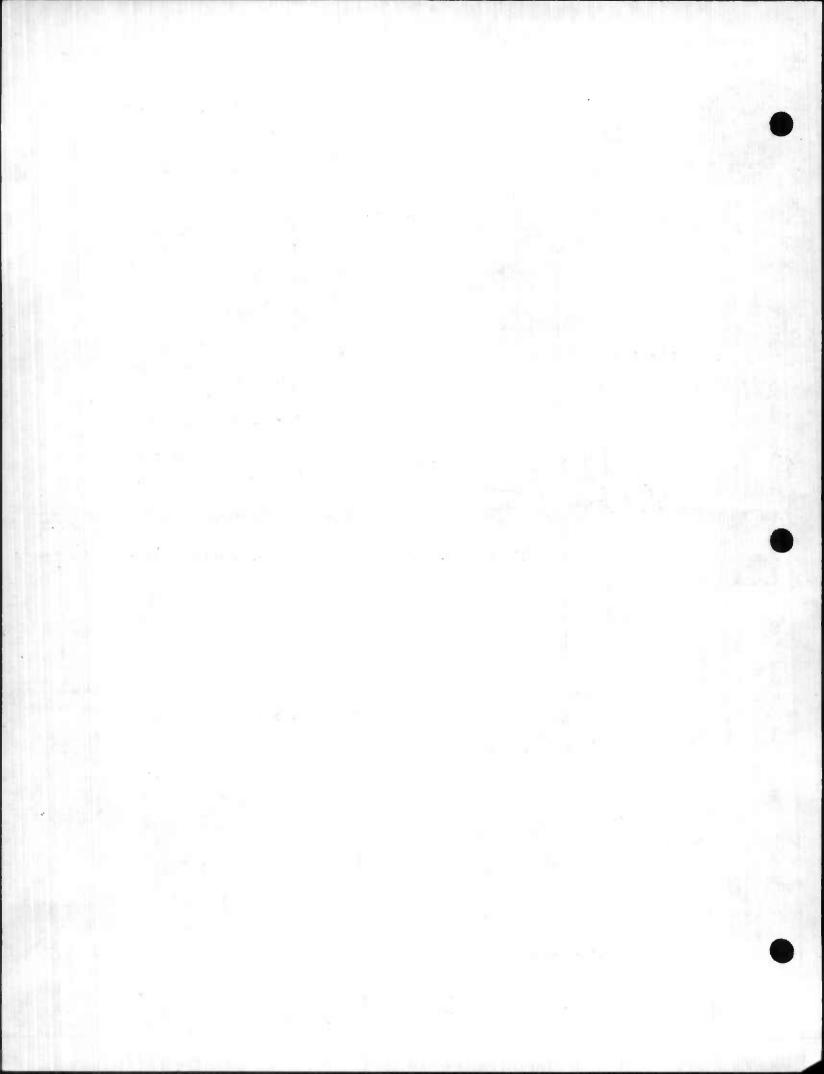
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 Yes 2 XNo Specify: White Specify: þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Conrad Haas Matida Hutchins 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Susan Miller / daughter 36 Gyro Drive Baltimore Md. 21220 20b. Place of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or pace. BelAir Memorial 2/2/99 BelAir Md. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signeture of Funeral Service Licenses Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart failure. List oply one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT /Medical Examiner HEROSCIEROTIC CALDIOVASCICA DISEASE Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai Due to (or as a consequence of) DE WEBITUS GUER attending p 88 SACRAL Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a 1 Yes 2 No 3 Probably 4 Whiknown signed i Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? been si 24e. Was an autopsy Completed page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No cartificata or Attending Physician: director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending within 24 hours eftar deeth.

To the Funeral Director: All completaly filled in by the fu 1 Tyes 2 No Investigation 2 Accident 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 0 d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete rele Battinere 2 Ma 11 3 1999 32. Registrar's Signature 31. Date filed (Month, Dey, Year)

State Registrar

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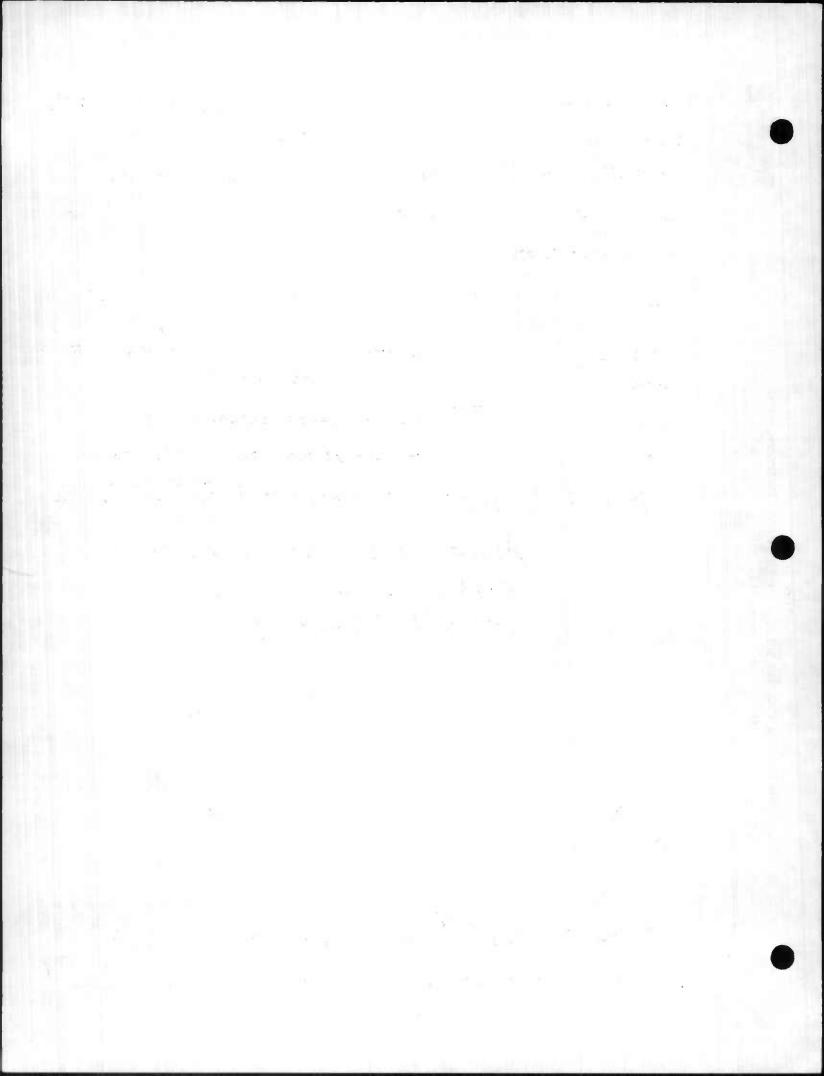


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	Physicia		1. Decedent's Nema (First, Middle Robert Louis Wr								Date of Dea Month nuary	Day 10	Year 199	3. Time of Death	
	/Medica Examine		4a Facility Na <i>ma (If not institution</i> Sinai Hospital	giva street and number	er)	-		1	Balt	wn, or Location	Location of Death 4c. County of Death n/a				
	Funeral Director		5. Social Security Number 218–30–6095 Usuel Residence of Decedent	6. Sex 7, M 2□ F	Age (In yrs. las	Yrs.	if Under Months	1 Yaar Days	If Under Hours	Min. (Date of Birth Month, Day	, Year) 1, 1936	Coun	iace (Stata or Foraign try)	
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Maryland 21215-0020	d outh	17. Fether's Name (First, Middle, Last) Arthur Wright Rosa		ar's Nama (Fin Booze	rst, Middla,	Maidan Suman	na)								
	alth end 27 is m		19a. Informant's Name/Relations Shirley Dean	nip (Type, Print) sis		2646	Kirk	Aver		altimor	ce, Mo	or, City or Town. 3. 21218	3		
Baltimore,	Pages nant of ant: If it ury or o		20a. Mathod of Disposition 1		cen	atary, crai utus	matory or or or or or or or or or or or or or	ial	Park	Feb.		Baltim	ore,	Md.	
Ball	pemit. Pag Department important: If any injury o		21. Signatura of Funeral Sarvice	Licensee .	tter	25	2. Na <i>m</i> a an 501 Gv	d Addra	ss of Facili s Fal	^{ly} Nutte ls PKW	r Fun Y Bal	eral Ho timore,	mes, Md.	Inc. 21216	
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	hys his aid	ation: 10	27. Menner of Daeth 1 Neturei 5 Pandin investig	28a. Data of to (Month, I		NOutpatie Bb. Tima o Injury		8c. Injur Wor	4 🗆 N		5 Dascribe 1	iance 6 ⊡Oth	er (Specif red	y)	
Division	ital or Attendent its after deat all Director: lied in by the	Certification:	3 Suicida 6 Could r 4 Homicide determ	ned Zoa. Plece of	injury - At home etc. (Specify)	a, farm, st	raat, factory	, offica			Location (S City or Tou		ber or Run	l Routa Number,	
	# C # C	Medical	(Check only 2 Medicat I	g Physician: To the be- Examiner: On the basis and mannar	of axamination		vastigation,	in my o	pinion, dea		t tha tima,	data and place,	and due to	tha cause(s)	
	5 1 5 2 .		29b. Signature and trule of certifie	extien	rell.	Mis	290) I	6 l	88		29d. Data rigne	190	Bay, Year)	
	7)		39. Name and address of person	who completed sause of	daath (Itam 2	3a) (Type,	Print) 91	8.	EATE	on G	e p	mD	21	254	

Registrar

3 1999

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 5 per F.H G-769 3/17/99 reb Certificate of Death mdent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Physician Month 1999 NIDAM reb /Medical 4c. Countyof Death 4b. City, Town, or Location of Death Facility Neme (If not institution, give str Examiner If Unde 7. Age (In yrs, last birthday) If Under 1 Year 8. Date of Birth (Month, Day 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F 218 66-4610 Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1□Yes 2☐No **Funeral Director** # 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -11. Marital Status Black, White, etc. 2 No 1944-ive Detes: 1946 Yes 2 Yes, Give 1 Never Merried 2 Merried 1□ Yes 2☑ No Completed by 3 ☐ Widowed 4 ☑ Divorced Yeer or Detes 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. CIQ MOT use retrieval) 15. Decedent's Education (Specify only highest grede completed) ondery (0-12) College (1-4or 5+) r's Name (First, Middle, Maiden Surname Eather's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type 19b. Meiling Address (Street and Number or Rural Route Number, City son other 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 20b. Place of Disposition (Name of cemetery, cremetory or other) Date 20c. Location - City or Town, State ò Department of important: If any injury or 21. Signature of Funeral Service Lidense 22. Name 11/1201 23a Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardishock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) cancer Examiner Physician/Medical Examiner disease Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yaa 2 No diabeter Dava hoid 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy 1 Yes 20 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 1 Netural 5 Pending

The law requires that the death certificate be assecuted for use as the burial-transit Records, P.O. Box 68760 page 2 should be certificate of Vital or Attending Physician: this Division

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filed within 72 hours after

21215-0020

Baltimore, Maryland

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Hygiene.

Pages 1 and 2 should be 1 nent of Health and Mental I int; If Nem 27 is marked of

funeral director, After death. within 24 hours after deat To the Funeral Director: completely filled in by Hospital

10

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. (Check only one)

investigation

6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Ptece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Elliattuty

290. Signature and title of certifie

29c. License number

Cone Wany

29d. Dete signed (Month, Day, Year) Jels 2, 1999

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

PATRYCE A. (ort MB 4565 Hemlock

31. Date filed (Month, Dey, Year) State Registrar

2 Accident

3 Suicide

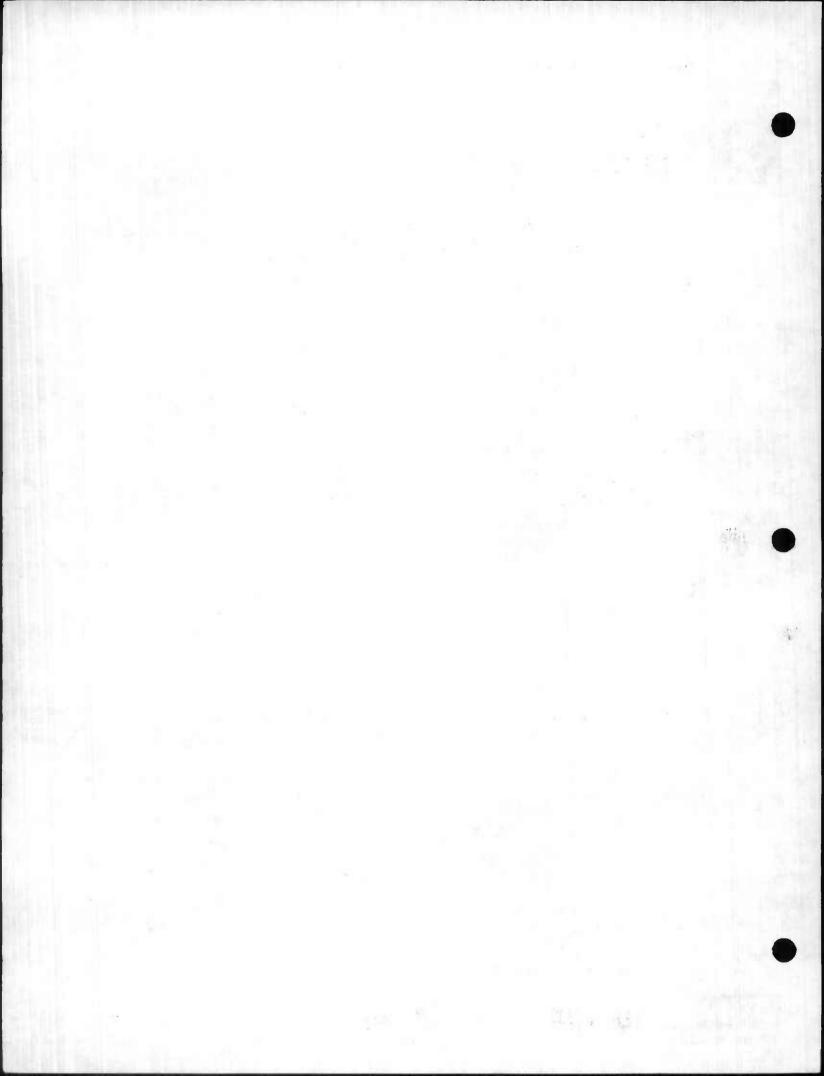
29a. Certifier

4 Homicide

3 1999

32 Registrar's Signeture

To the



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:55 AM January 30, 1999

4b. City, Town, or Location of Death 4c. County of Death Dorothy Zentz /Medical 4a Facility Name (If not institution, give street and number) Examiner 10 Patapsco Road Linthicum Anne Arundel If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Deys Months Hours 1 M 2 XF 74 Yrs March 17, 1924 Maryland 217-12-8610 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2X No Director Md. Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Patapsco Road 21090 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yea 2 ☐ No If Yes, Give Year or Dates; 13. Wes Decedent of Hispanic Origin? (Specify Yea or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, 11. Maritai Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: by 3 Noticed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businaas/Industry Roper Eastern College (1-4or 5+) Elementary/Secondary (0-12) Factory Worker Manufacturing Co. 8th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) 8 Mary Virginia Herman John H. Nagengast 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 10 Patapsco Road Linthicum, Maryland 21090 Date Date, 200 Location City or Town, State Vickie Zentz (Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State Finksburg Cemetery 2/2/99 Finksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, k, or heart feilura. List only one cause on each line. Approximate triterval Between Onset and Death Immediate Cause (Finel disaese or condition resulting in death) Examiner Sequentially list conditions, if eny, leading to immediate cause, Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as e consequence of): Part It. Other significant conditions contributing to death buy not resulting in the underlying ceuse given in-Pert I. 23b. Did tobacco usa contributa to the cause of death? 4 Unknown 1 ☐ Yaa 2 ☐ No 3 ☐ Probably à 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 No 2 0 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Yea 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide

sician and burial-transit The law requires that the death certificate be axecuted physician the burla Box 68760. US. 1 P.O. Records, page 2 of Vital Physician: this funeral After Division or Attending death.

Funeral

Director

r 28a-f show

"natural", or items 23s or

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercises page.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

To the Hospital or Attendify within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 0

State Registrar

Medical

29b. Signature and title of certified

29c. License number 14798

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as atated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated.

29d. Data signed (Month, Day, Year)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- 716 maiden Choice Lane Ste 301 Balto MD 21228 Pirzadeh .Shams MID

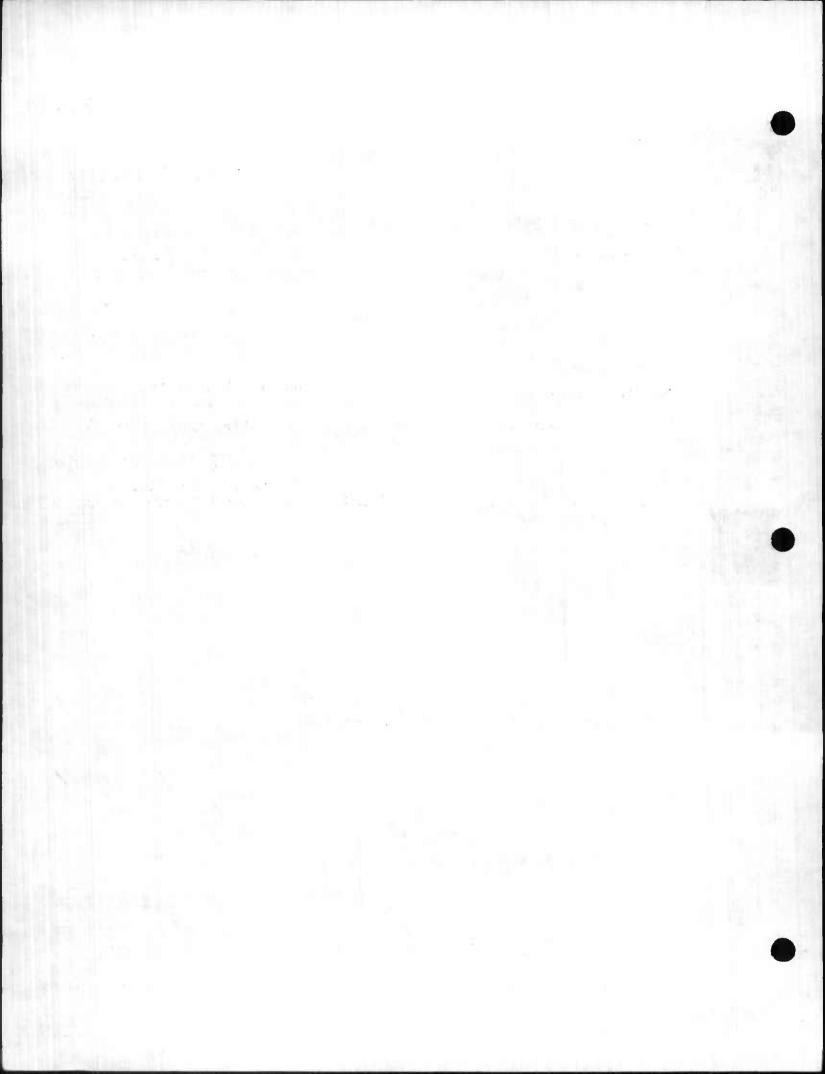
31. Date filed (Month, Day, Year)

4 | Homicide

29e. Certifier (Check only one)

> 32 Registrar's Signature Clener

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

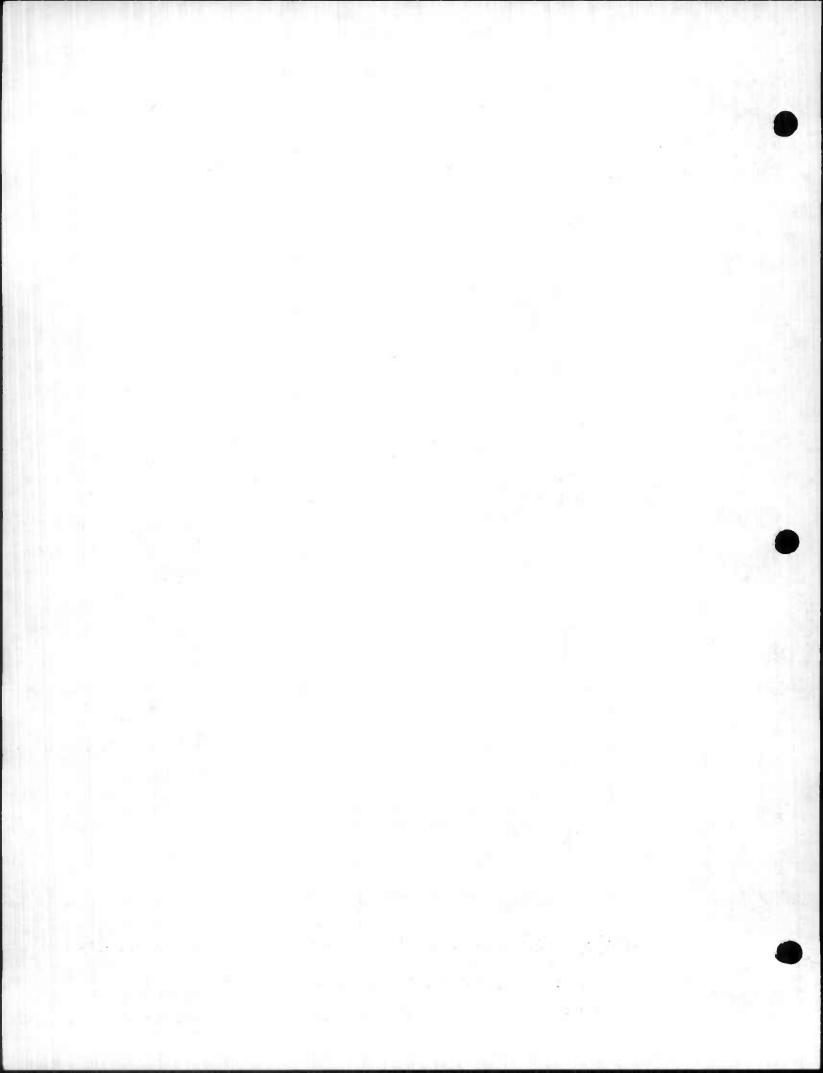


State of Maryland / Department of Health and Mental Hygiene 9 0 2 7 5 9

sual Rasidance of Decedant Da. Stata 10b. County MD Anne Aru: De. Street and Number 373 Stonehouse D. I. Maritel Status 1 Nevar Merried 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highast grave) Elementery/Secondery (0-12) I. Z. Fathar's Nama (First, Middla, Last) Vandergrift Ashbut Se. Informent's Name/Reletionship (7) Deborah Barghorn/ Da. Mathod of Disposition 1 Buriel 2 © Cremation 3 4 4 Donation 5 Other (Specify	Ashbuastreat and number) Prive ax 7. Aga Ashbuastreat and number) Prive 7. Aga Andel rive 12. Was Decedent Earmed Forcas? 1 Ayes 2 lo New Year or Datas: ucation da completed) College (1-4or 5- urn Type, Print) daughter Ramoulton State	(In yrs. I 68 10c. City Sever iver in U,	16a. De (G //# Mast	Month Location Park 101. Z 21 3. Was Dec II Yas, sp. 1 Yes secedant's Us kind of ya. DO NOT CET E1	ler 1 Years Days Zip Coda 146 Decify Cub 2 No Sual Occupant dona usa retire CCTT	Seve If Under 24 H Hours Mi Hours Mi Hours Mi Mi Mi Mispanic Origin? In Maxican, Pur Specify: Detion during most of wid) ician	(Specify Yas or N arto Ricen, etc.) vorking	Dey 14, 19 14, 19 14, 19 14, 19 14, 19 15 16, County Anne 10g. Citizen of V USA 10g. Citizen of V USA 14. Rac Blac Specify 16b. Kind of Bu Electr:	9. Birthp County Virg	olaca (Stata or Fora- lity) 1 nia Od. Insida City Limi 1 Yas 2 1 1 otry? can Indian, etc.		
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373 Stonehouse D Social Security Number 216-24-9984 Sual Rasidance of Decedant Da. Stata 10b. County MD Anne Aru: De. Street and Number 373 Stonehouse D Maritel Status 1 Nevar Merried 2 Married 3 Widowed 4 Divorced (Specify only highast grau Elementery/Secondery (0-12) 1. Fathar's Nama (First, Middla, Last) Vandergrift Ashbut De. Informent's Name/Reletionship (7) Deborah Barghorn/Cola. Mathod of Disposition 1 Buriel 2 Mccremation 3 4 Donation 5 Other (Specify	ndel rive 12. Was Decedent E Amed Forcas? 12. Yes 2 N If Yas, Give Yaar or Datas: ucation da completed) College (1-4or 5- urn Type, Print) daughter Ramovalinem State	68 10c. City Seve	Yrs y, Town or erna s. 1 16a. De (G) /// // // // Mast	Month Location Park 101. Z 21 3. Was Dec II Yas, sp. 1 Yes secedant's Us kind of ya. DO NOT CET E1	ler 1 Years Days Zip Coda 146 Decify Cub 2 No Sual Occupant dona usa retire CCTT	Seve If Under 24 H Hours Mi Ho	erna Parl- rs. 8. Data of Bi n. Manner, b Mann	Anne Inh Yaar) 10g. Citizen of V USA O- 14. Rac Blac Specify 16b. Kind of Bu Electr:	9. Birthp County Virg	olaca (Stata or Fora- lity) 1 nia Od. Insida City Limi 1 Yas 2 1 1 otry? can Indian, etc.		
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equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Direcase or injury sat initiated events saulling in death) Last	b	Due to (a	ras a con	sequence o	d):							
art II. Other significant conditions co	ontributing to death bu	t not resu	ulting in th	e underlying	g cause gi	ven in Part I.	23b. Die	I tobaçco use co	ntribute t	o the cause of dea		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								Ves 2□ No	3□Pro	bebly 4 Unkn		
							24a, Wa	s an autopsy formed?	div op	ere autopsy finding raliable prior to impletion of cause death?		
							10	Yes 200 No	11	□Yes 2□No		
5. Was case referred to medical						26. Place of C	eath (Check only	one)				
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1. Manneyef Death 1. Deatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)					28d, Describe	cribe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju			street, fact	bry, office		28f. Location City or To	(Street and Numbown, Stata)	per or Run	al Routa Number,		
	iner: On the besis of	axaminat										
9b. Signetura end titla of certifier				2	29c. Licen	sa number		29d. Dete signe	d (Month,	Day, Year)		
· Onan	nonz				D	3950.	5	Jan.	14,	1999		
O. Neme and address of person who o					G	lan B	umie	MD.	2110	80		
9999	Was case referred to medical examiner? 1 Yes 25 To Manney Death 1 Manual 2 Accident 3 Suicide 4 Homicide Da. Cartiflar (Check only 2 Medical Examined) b. Signetura end titla of certifler Neme and address of person who could be the manual of the certifler (Check only 2 Medical Examined) Date filed (Month, Day, Year)	was case referred to medical examiner: On the best of signed and address of person who completed cause of death but the cartifier (Check only care). Neme and address of person who completed cause of death but the care of	Was case referred to medical examiner? Was case referred to medical examiner? Due to form the property of	Was case referred to medical examiner? Was case referred to medical examiner Due to (or as a conditions and to the conditions are conditions)	Due to (or as a consequence of the contribution of the contributio	Due to (or as a consequence of): Due to (or as a consequence of):	Due to (or as a consequence of): Due to (or as a consequence of):	Due to (or as a consequence of): Due to	Due to (or as a consequence of): Due to (or as a consequence of):	Due to (or as a consequence of): Due to (or as a consequence of):		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q

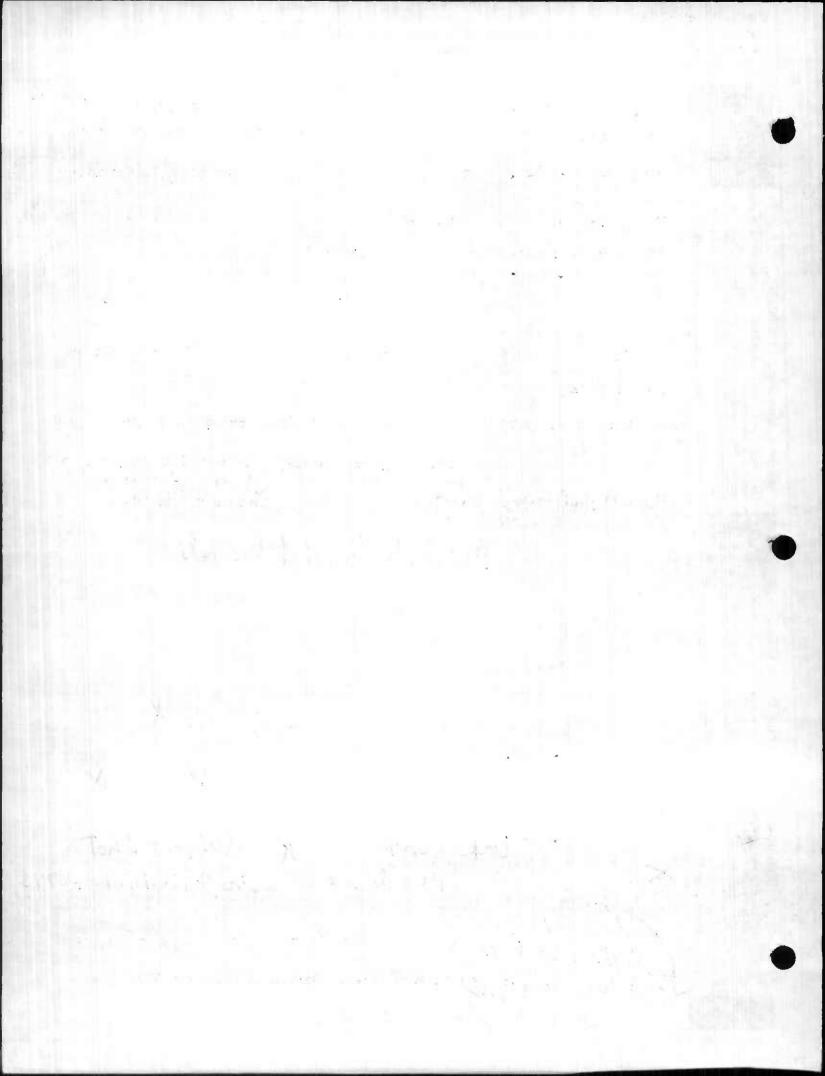
-		1. Decedant's Nar	ne (First, Middle, L	ast)					2. Date of Dear		М	3. Time of Dea		
Physic /Med		Mamie	Louise	Ashby	7				Month January		Year)	8:30 P		
Exam		4a. Facility Name	(If not institution, gi	ve street end numbe	r)			4b. Clty, Town, or	Location of Death	4c. County of				
		Cuppett-	Weeks Nu	rsing Home	2			0aklan	d	Gar	rett			
، Funera	_	5. Social Security		Sex 7. A 1 □ M 2 ☑ F	age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	Year)	Coun			
Directo		236-50-8 Usual Residence	0/1	**	85				Aug. 20,	, 1913	Mary	land		
show	_	10a. State	10b. County			own or Loca					10	Od. Inside City Lir		
No M	ecto	MD		rett	1	Mt. La	ke Park					1 X Yes 2□		
with w	P	10e. Street and Nu					10f. Zip Code	1.550	1	0g. Citizen of W	hat Coun	try?		
eath	era	Meadow W	oods East	12. Was Deceden	t Ever in It S	12 1/2		1550	posity Ves or No	USA	ce - Americen indian,			
filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or Itama 23a or 28a-f show ent, the Hesical Examine must be notified as	by Funeral Director	1 Never Man	ried 2 Narried 4 □ Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Dates	? No		es, specify Cubs	lispanic Origin? (S an, Mexicen, Puert Specify:	o Ricen, etc.)		, White, a			
2 ho	Completed	10	15. Decedent's E	ducetion	10	6a. Deceder	it's Usuai Occup	ation		18b. Kind of Bus				
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and Mental Hygiene. Is marked other than raumatic event, the H	2	Luther	L.	Riley				Rosie	Jane	Berr				
3			lame/Relationship					and Number or Ru				Code)		
Healt Fm 2		20a. Method of Dis		/Daughter				0akland				- Chata		
permit. Peges I and 2 Department of Health e Important: If Item 27 Is any injury or other tra once.		1 Burial 2		□Removal from State	9		ion (Name of tory or other place Cemete		1/11/99	20c.Location - 0 Perra Al	•			
partm porta inju			upopul Service Lige				lame and Addres				,			
Depa Impor		1 Place	De N J	Ditter 1		Ste	wart Fu	neral Ho	me	10 01 F				
		23a. Part1. Enter the disease, or complications that caused the daath. Do not antar the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.									550	Approximate		
hysician		SHOCK, OF HER	in randre. List only	ona cause on each	iina.						i	interval Batweer Onset and Deat		
/Medical	н	Immediate Cause disease or condition		athero	sclerot	ic ca	rdiovaso	cular dis	sease		1	5 minute		
Examiner		Due to (or as a consequence of):												
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been sig should b	Pa								24a. Was a	n autopsy	24b. We	re autopsy findir		
. 40	Completed								parform	ned?	con	llable prior to apletion of ceuse eath?		
	Eo								1 □ Ya	s 2XINo	7.1-	Yes 2□ No		
is certificate director, pag	BeC	25. Was cese rafer	red to medicei				7.77	28. Placa of Dea	th (Check only on					
6 X	To	examiner? 1 ☐ Yes 2 🖔	No	Hospital: 1 ☐ inpati	ient 2 ER/	Outpatient	3□ DOA Othe		ome 5 Reside		(Specify)		
0 0		27. Mannar of Deat	th 5 Pending	28a. Date of inj (Month, Da	ury 28b	. Time of Injury	28c. injury Work		28d. Describe ho					
al di s	量	2 Accidant	investigation	n				Yas 2 □ No						
al di s	8	3 ☐ Suicide 4 ☐ Homlcida	6 Could not b determined	286. Place of in	jury - At home, tc. (Specify)	farm, street	, factory, office		28f. Location (St. City or Town		r or Rural	Route Number,		
ector: After this by the funeral di	rtifica		4 Homicida building, etc. (Specify) City or Town, Stete)											
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ifter death. Nector: After this in by the funeral di			1 Certifying Ph 2 Madical Exam	niner: On the basis of and manner s	ated.	29b. Signature end title of certifier 29c. License number 29d, Date signed (Mon								
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State of Maryland / Department of Health and Mental Hygiene 9 9 0276

						C	ertifica	ate of	Death	R	eg. No.	0 6	1	•
		1. Decedent's Name (First, I	Aiddle, Las	1)						2. Date of Dee		Year	3. Time	of Death
	Physician /Medical	Ellen Chi	istir	na	ASHBY					Month January	Day 10, 19		2:4	1 AM
9	Examiner	4a Facility Neme (If not inst	tution, give						4b. City, Town, or	Location of Death	4c. County			
	<u> </u>	Garrett Count	y Men	norial	Hospi	tal			0akla			arrett		
	Funeral	5. Social Security Number	6. Se		7. Age (In y	rrs. last birthda	Month	der 1 Yea	r If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day	Veerl	9. Birthpled	ce (Stet	e or Foreign
н	Director	217-28-9253	1[□M 2\ F	69	Yrs	Mont	is vey	S TIOUTS NAME	Aug. 9,	1929	West V		inia
	P	Usual Residence of Decede				0: -								01. 11. 1
	anylar show	10a. State 10b. Co			100.	City, Town or						100		City Limits
	Ba-f	MD	Gai	rett				land						2 2 K) 140
	or 2	10e. Street and Number					10f.	Zip Code			0g. Citizen of		n	
	ath w	217 E. Ashby-	Ellis						21550		US			
21215-0020	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination and a confined at To Be Completed by Funeral Director	3 X Widowed 4 □ Dive		12. Wes Dec Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2∭ No ive	n U,S. 1		cedent of specify Cu	Hispenic Origin? (S ban, Mexican, Puer o Specify:	Specify Yes or No- rto Rican, etc.)		ce - American ck, White, etc		
0-0	2 ho	15. Dec	edent's Edu	ucation		16e. De	cedent's U	sual Occ	upation	nekina	16b. Kind of B	usiness/Indu	stry	
21	ified within 72 hour Hygiene. other than "naturalent, the Medical ed.	(Specify only h			1-4or 5+)	life	DO NO	Tuse reti	e during most of wo red)	nkiig				
	od wil	9]	louse	wife			Hom	e		
Maryland	be file d oth event	17. Fether's Neme (First, Min	idie, Last)						18. Mother's Na	me (First, Middle,	Meiden Sumer	ne)		
Va Va	should be family and Mental in marked of urmatic eve	Clayton	osepl	n S	Slauba	ugh			Lucy	Anogle	Pa	ugh		
a	2 sho and is mu	19a. Informent's Name/Rele							et and Number or A					
	1 end 1 Health Sem 27 other tr	Judy A. Tusin	ig/Dai	ighter				-	-Ellis Ro					1550
ore	of He	20e. Method of Disposition 1 X Burial 2 ☐ Crema	ion 3 🗆	Damoval from	State 201	b. Plece of Di cemetery, o	sposition (i	Neme of or other p	lece)	Date	20c. Location	- City or Town	n, Stete	
<u>=</u>	Part in	4 Donation 5 Oth			G	Garrett	Co.	Mem.	Gardens	1/13/99	0aklan	d, MD		
Baltimore,	permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trau once.	21. Signature of Funerel Se	vice Licens	9					ress of Facility Funeral H					
Ш	20 = 3 9	2 roller	X X	Destar					cond St.,		MD 2	1550		
	Physician /Medical Examiner	23a. Pert1. Enter the diseas shock, or heart feilure. Immediate Cause (Final disease or condition resulting in deeth)		. 1	leto	o (or es e con	2	-		est				nate Between Id Deeth
Box 68760,	at the death certificate be executed by the attending physician and letached for use as the bunat-transit Physician/Medical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	{	c		o (or as e con								
	as that the death cer igned by the attendir be detached for use by Physician/A	Part II. Other algnificant con	ditions co	ntributing to d	leath but not	resulting in th	e underiyin	g cause	given in Pert I.	23b. Dld t	obacco use co	ontribute to t	he caus	e of death?
P.0	at the	NITI	00	11						101	es 2 No	3 Probe	bly 4	Unknown
	as the	10 11	1//											
Records,	been s should should									24e. Was perfor	an autopsy med?	evail	eble pri	sy findings or to of cause
<u>e</u>										1 U Y		10	Yes 2	!∐ No
Vital	Physician: The laver this certificate has rel director, page 2 To Be Comp	25. Wes case referred to me examiner?		Hospital:				c	Whor	eth (Check only o				
o	this care direction of the care direction of	1 ☐ Yes 2 ☒ No		1 124		2 ER/Outpa 28b. Tim		DUA	4 Linuising	Home 5 ☐ Resid				
L C	ling ling ling fune fune	1 Natural 5 □ P	ending restigation	(Mon	of Injury oth, Dey Year) Injur		28c. In W	ork? □ Yes 2 □ No	200. 0030/100	OW IIIJUIY OCCU	1100		
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completaly filled in by the funeral Medical Certification:	3 Sulcide 6 □ C	ould not be stermined	289. Place	e of Injury - A ling, etc. (Spe	at home, farm,				28f. Location (5 City or Ton		ber or Rurel I	Route A	'umber,
	To the Hospital of within 24 hours a To the Funeral D completally filled I Medical Ce			iner: On the b					time, date and plac opinion, death occ					e(s)
	With it To th comp	29b. Signature end title of ce	rtifier					29c. Lice	nse number		29d. Dete sign)
		1						Do	02656	8	1-1	2-3	SE	
		30. Neme and address of pe	rson who c	ompleted cau	se of death (Item 23e) (Tvi	oe, Print)	-			•			
	3	Dr. Roger Le						Terra	a Alta, W	est Viro	nia 2	6764		
	State	31. Date filed (Month, Dey,		32. F	Registrer's Si		4		L.	+++6				

Physician /Medical	1. Decedent's Name (First, Middle, La	st)						Reg. No.		7		
	Darryl Maurice A				2. Date of De Month JANUA	Day	Year 999	3. Time of Death 0300 AM				
	4a Facility Neme (If not Institution, given 1210 DEVONSHIRE	e street end numbe	er)			4b. City, Town, o	or Location of Deat		of Death	ORGES		
Director	231-08-85/0	Sex 7./	Age (In yrs. k	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		. (Month, Dey, Year)				
0	Usual Residence of Decedent 10a. State 10b. County VA Campbel	1		, Town or Loc	cation			10d. Inalde City Limits 1 ☐ Yes 2X No				
ifar death with the Mar if tems 23s or 28s-f si the rough be notified Funeral Director	10e. Street and Number 122 DaddyRabbit				10f. Zip Code 24550			10g. Citizen of V	What Coun	try?		
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manyland Department of Hastin and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-1 show any lolury or other traumatic event, the Madical Examples must be incitiled at ansaly lolury or other traumatic event, the Madical Examples must be incitiled at ansaly lolury or other traumatic event, the Madical Examples must be incitiled at ansaly lolury or other traumatic event, the Madical Examples must be incitled at ansaly lolure. To Be Completed by Funeral Director	11. Marital Status \(\sum \text{\text{Married}} 2 \sum \text{Married} \) 3 \(\sum \text{Widowed} 4 \sum \text{Divorced} \)	12. Was Deceder Armed Force: 1 Yes 20 If Yes, Give Year or Dates	s? XNo	lf lf	Vas Decedent of H Yes, specify Cub	an, Mexican, Pu	(Specify Yea or No erto Rican, etc.)	Blad	14. Rece - American Indian, Black, White, etc. Specify: Black			
led within 72 hou lygiene. The than naturally the Medical Completed	15. Decedent's E (Specify only highest gra- Elementery/Secondary (0-12)		or 5+)	(Give i	ent's Usual Occup kind of work done OO NOT use retire CK Driver	during most of v d)	vorking	16b. Kind of Bu				
should be filed within 72 hours eff of Mental Hygiene. merked other than "natural", or immite event, the Medical Exam To Be Completed by F	17. Father's Name (First, Middle, Last, Lewis C. Avery)		1100	K DIIVEI	18. Mother's N	lame (First, Middle .ne Oulds	, Maiden Sumen		ingo		
1 and 2 should Health end Men em 27 la merke other traumatic	19a. Informant's Name/Relationship (Mrs, Geraline 0. 20a. Method of Disposition		20b. PI	122 [addyRabb	oit Lane	Rurel Route Numb e, Evingt		inia	24550		
permit. Pages Department of I Important: If it any Injury or o ance.	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of Funerei Service Liceration of Funerei Liceration of Funerei Service Liceration of Funerei Liceration of Funerei Liceration of Funerei Liceration of Funerei Liceration of Funerei Liceration of Funerei Liceration of Funerei Liceration of Funerei Liceration of Funerei Liceration of Funerei Liceration of Funerei Liceration of F	y)	Mt.	Ever	preen Cer Name end Addre	netery	1-28-99 Carl B. H 018 Fifth	Evingto utcherso				
ate be executed thysician and the bunal-transit dical Examiner	Immediate Cause (Finel disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	a	Due to (or	as a consequence as a c	uence of): uence of):	slot	Woure	l .				
d by the	Part II. Other significant conditions of	d. contributing to death	n but not resu	Iting in the ur	iderlying ceuse gi	ven in Part I.		tobacco use co	tobacco use contributs to the cause of deat			
ate has been signed, pege 2 should be d	Α.							a an autopsy ormed?	av	ere autopay findings allable prior to mpletion of ceuse death?		
The peg	25. Was cese referred to medicel examiner?						Death (Check only	Yes 2□No	0	Yes 2□ No		
Hospital or Attending Ph. 4 hours after death. Funeral Director: After th. lay filled in by the funeral size (Certification: Size)	27. Manner of Deeth 1 Natural 2 Accident 3 Suicide 6 Could not be determined		Injury - At ho etc. (Specify st of my knows of examinati	viedge, deeth	28c. Inju Wo 1 = cet, factory, office occurred at the ti	ny at nrk?] Yes 22 No me, date and pl	28f. Location City or 7 of the company of the compa	(Street and Number, Stete) 2 (Street and Number, Stete)	ber or Rurs	IT Route Number, 257 Y. teted.		
	29b. Signature and fittle of certifier 30 Name, and address of person who	arless	death (Item	23a) (Type,	Print)	.M.E.	re, Mary	29d. Dete signe JANUAR	Y 24,			



State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** Seymour Ackerman 1999 Jan 21 8:00 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Genesis ElderCare -The Pines Talbot Easton | If Under 1 Yaar | If Under 24 Hrs. | 8. Dete of Birth | 9. Birthplace (Stata or Foreign | Months | Deys | Hours | Min. | November 21, 1918 | New York Sex 1□ M 2□ F 7. Age (In yrs. last birthday) **Funeral** 114-10-2238 80 Yrs. Director Usual Rasidanca of Decedant with the Manyland 10e. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examinar must be notified at 1 Yas X No Director PA Cumberland Carlisle 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 17013 1 Longsdorf Way USA 2 should be filed within 72 hours efter death and Mantal Hygiana. Is marked other than "natural", or items 23. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 No ff Yas, Giva Yaar or Datas: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Never Marriad 2 ☐ Married White 1 Yas 2 No Specify: altimore, Maryland 21215-0020 þ 3 N Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) UP COMECTIST/ 15. Decedant's Education (Specify only highast grada completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Federal Govt. 18. Mothar's Nama (First, Middla, Meiden Sumame) 17. Fether's Nama (First, Middla, Last) Bernard Ackerman Rebecca Breslov Ackerman 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 sh Department of Haaith and Important: If itam 27 is m any injury or other traum once. 3 Wicklow Crt. Waldorf, MD 20602 Robert M. Ackerman/Son 20a. Mathod of Disposition
1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 1/23/99 Alexandria, VA 22. Nama and Address of Fecility AREHART-ECHOLS FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Flnai disaasa or condition resulting in death) Examiner Examiner ettanding physician and for usa as the burial-trans Sequantielly list conditions, if any, laading to immediata causa. Enter Undarlying Cause (Disease or injury that initiated avents rasulting in daath) Last that the death certificate be exec P.O. Box 68760 Physiclan/Medical Part It. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part It. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Munknown Hypedension signed by Division of Vital Records, þ 24b. Wara autopsy findings available prior to complation of cause of death? Diabeter mellitus Completed 24a. Was an autopsy performed? paga 2 1 ☐ Yas > No 1 ☐ Yas > No cartificeta 25. Was casa rafarred to medical axaminar? 26. Pleca of Death (Check only one) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4X Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) To this funarai 27. Manner of Death Natural 28b. Time of 28d. Dascribe how injury occurred 28a. Data of injury (Month, Day Year) 28c. injury at Work? Certification: Aftar Hospital or Attending 5 Panding invastigation s efter death. 1 Tas 2 No 2 Accidant 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homleida 24 hours Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the tima, data and placa, and due to the cause(s) and mannar stated. edicai (Check only one) within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signature end title of cert 1.22.99 30. Nama and addrass of person who completed edusa of death (item 23a) (Type, Print) AVENUE EASTON MD 21601 MO 508 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

Registrar

JAN 25

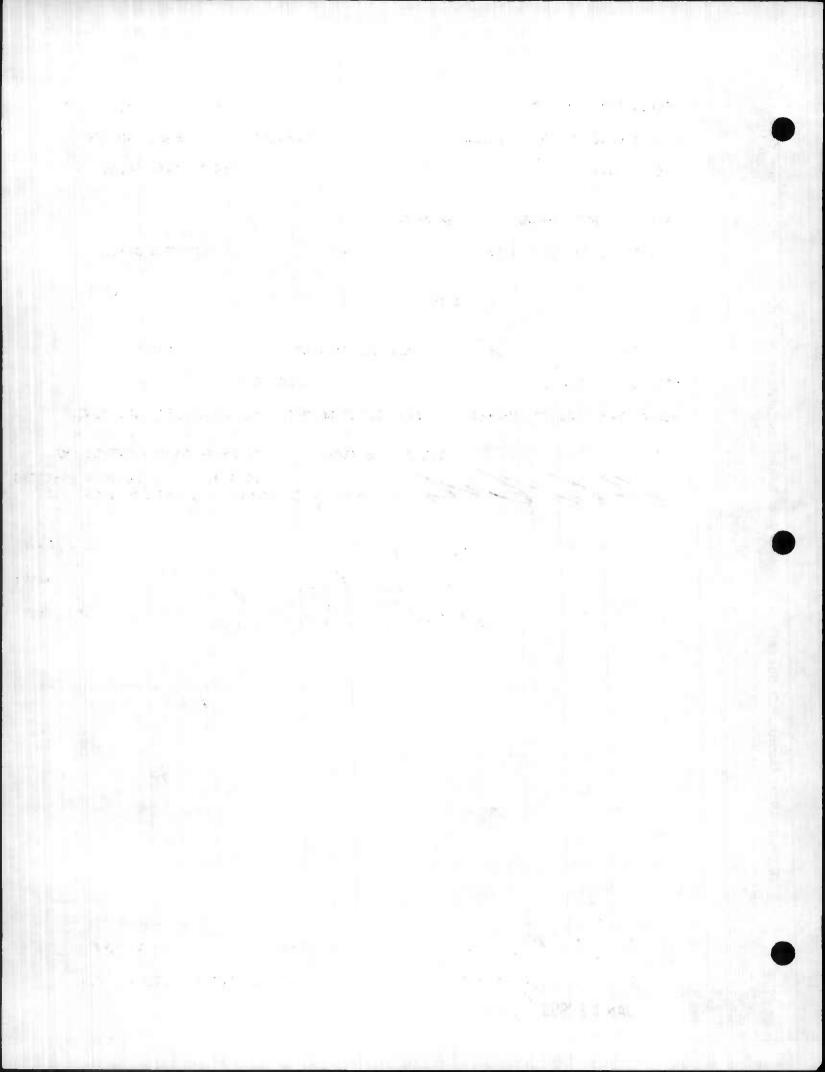
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State of Maryland / Department of Health and Mental Hygiene 9 0 2 7 6 4

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Physician /Medical	_	Florence	D. B	ensen							Jan.	20 1	1999	3:33 AV	1
Examiner	4	a Facility Name (If no Anne Arunde I			imber)				Annapo	lis	ocation of Death	Anne	unty of Death Arundel		
Funeral Director		. Social Security Num 056-20-0625	ber 6. S	Sex IDM X F	7. Age (In yr. 92	s. last birthday) Yrs.	If Under Months	1 Year Deys		24 Hrs. Min.	8. Date of Bin (Month, Da	1906	9. Birth	nplace (Stete or I untry) OFK	Fore
	-	Jsual Residence of De Oe. Stata 10	ocedent Ob. County		100.0	City, Town or Le	ocation						1	10d. Inside City	Lim
or and			nne Arund	hel .		napolis	oodtion							1 ☐ Yes 2	X
or 28a-f show	3	0e. Street and Number				Παωτίδ	10f. Zip	Code				10a Citizen	of What Cor	untry?	
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hysiene. her than "nature nt, the Medical I			Decedent's Ed			16a. Dece (Giva	dent's Usua kind of wo	al Occu	pation during mos	t of work	king	16b. Kind	of Business/I	ndustry	
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alth end h	- 1 -	19a. Informant's Name loger Bensen		Type, Print)							rel Route Numbe Connectic			ip Code)	
Department of health and Mental hygiene. Theorem: If item 27 is marked other than "natural; or important; If item 27 is marked other than "natural; or into injury or other traumatic event, the Madrail Evantuate. To Be Completed by F	2	0a. Method of Dispos 1 Burlai 2 0 4 Donation 5	cremation 3		State	Place of Disponents of Dispone	matory or o	ther ple	eca)	1/3	Date 0/99		ion - City or 1		
Depertm Importar any inju	100	1. Signature of Funer			CA	2	2. Nama an	d Addr	ess of Facili	y Joh	n M. Tayl	or Fune	ral Hom	e,Inc.	
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is certificate has been signed by the ettend if director, page 2 should be deteched for us. To Be Completed by Physician/	200										24a. Was	an eutopsy rmed?		Were eutopsy fin available prior to completion of cau of death?	ding use
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certificate irector, pag	2	5. Was case referred	to medical						26. Place	of Dea	th (Check only o				
s certificate has director, page 2 To Be Comp		exeminer?		Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 DC	DA O	ther		oma 5 Resi		Other (Spec	city)	
within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	2	7. Manner of Death 1 Natural 2 Accident	5 ☐ Pending Investigation	28a, Dete (Mor	of Injury oth, Day Year)	28b. Time of Injury	of 2	8c. Inju	uryat ork?]Yes 2□	No	28d. Describe	how injury o	ccurred		
d in by the		3 ☐ Suicide 6 4 ☐ Homicide	Could not b determined	e 28e. Plac build	a of Injury - At ling, etc. (Spec	home, farm, st	reet, factory	y, office			28f. Location (City or To	Street and N vn, Stete)	lumber or Ru	iral Route Numb	er,
Within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral Medical Certification:	2	29e. Certifier (Check only one)	Cartifying Ph	niner: On the b	e best of my kr pasis of examination	nowledge, deat netion and/or in	h occurred ivestigation,	et the t , in my	ime, dete ar opinion, des	d piace, th occur	end due to the rred at the time,	cause(s) an dete and pla	d menner as ace, and due	stated. to the cause(s)	
Ne the		9b. Signature and to	o confor		,		290	c. Licen	sa number			29d. Data s	igned (Monti	h, Dey, Year)	
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		0. Name and address Lisa A. DilVa					Print)			/arvI:	and 21401	, 207			
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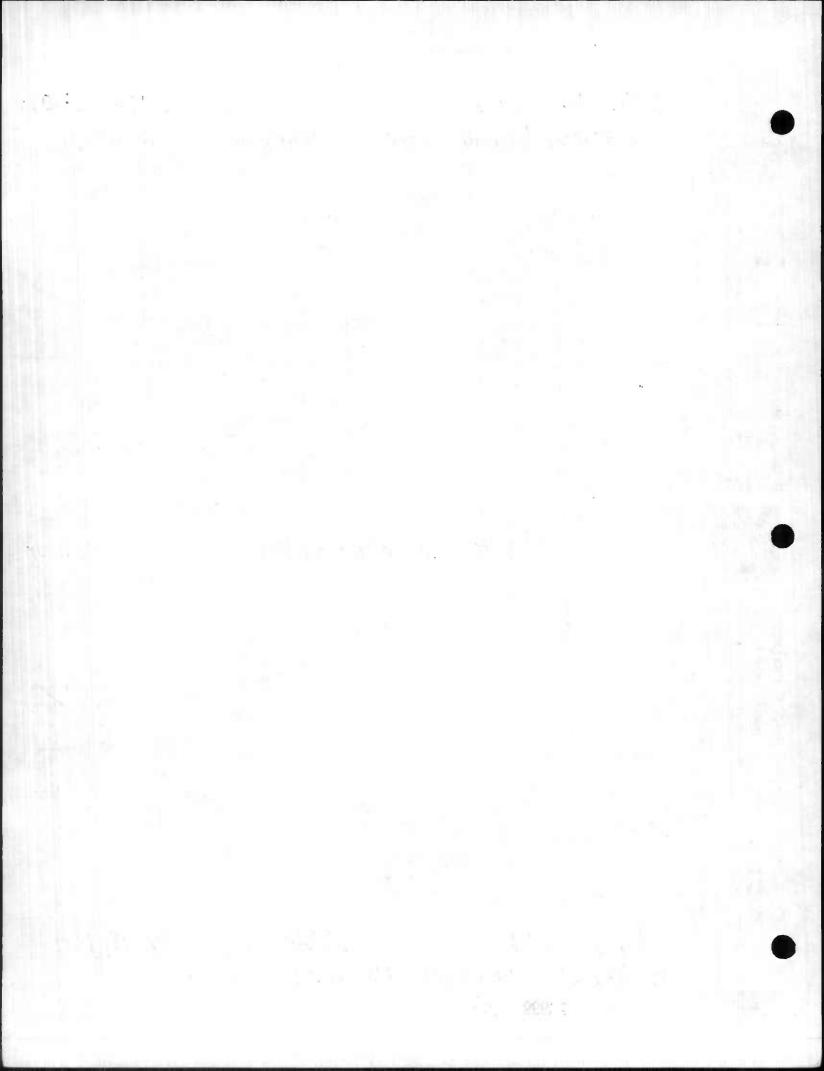
State of Maryland / Department of Health and Mental Hygiene Q

d. 1/	1/26/99 SM AACO H		Cer	tificate of	Death		Reg. No.	- 1	0.71	,	
ysician	1. Decedent's Name (First, Middle, Last					2. Date of De Month	Day	Year	3. Tima of Death		
ledical	GERALD EARL BOWCU' 4a Facility Name (If not institution, give				4b. City, Town, or	Location of Deat	20 1 4c. County	eg of Death	- I - I - I		
aminer	ANNE ARUNDEL MEDI				ANNAPOLIS	5	ANNE A		L		
eral ctor	328 40 0923	AM OF E	last birthdey) 54 Yrs.	If Under 1 Yea Months Day			1h, Year) 0, 1934	9. Birthpla Count UTAH	ace (State or Foreign ry)		
by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits		
tor	MARYLAND ANNE ARU	NDEL ANI	NAPOLIS	5					1 ☐ Yes 2 No		
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Count	ry?		
	1757 POINT NO POI			21401			UNITED S				
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: KOREA		Was Decedent of f Yes, specify Cu	Hispanic Origin? (: ban, Mexican, Pue o Specify:	Specify Yes or No nto Rican, etc.)	Specify	Race - American Indian, Black, White, etc. ecity: WHITE			
Completed	15. Decadent's Edu (Specify only highest grad	cation a completed)	16a. Deced	dent's Usual Occi	upetion e during most of wo	orkina	16b. Kind of B	usiness/Indi	ustry	-	
mple	Elementary/Secondary (0-12)	College (1-4or 5+)			e during most of wo		TITALANC	173			
Co	12 17. Father's Name (First, Middle, Last)	5+	FINANC	CIAL MAN	_	me (First, Middle	FINANC			_	
To Be	LORENZO BOWCUTT	JR.				EARL					
_	19a. Informant's Name/Relationship (7) BELVA JEAN BOWCUT			-	et end Number or F						
	20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	emetery, cren	esition (Neme of metary or other particle) CEMETER		Dete 1-25-99	20c. Location -				
any injury once.	21. Signature of Funeral Service License			Name and Add	race of English					7	
	Mar of	108	1/	47 DUKE	OF GLOUCI				L HOME, INC D. 21401	3	
ian ical	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the deat							Approximete Interval Between		
	Immediate Cause (Finel disease or condition		. 5h	ock					Onset and Death 24 Hours		
I, I	resulting in death) Due to (or as a consequenca of):										
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Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c. Alleted caroliom yoguthy										
dlcai	that initiated events	c. dilet	r as a conseq	uence of):	on lot	athy		i	- /		
	resulting in death) Last	200 10 (0	. 20 2 0011000	- 3 01/1				i			
and		5									
Physician/M	Part II. Other significant conditions co	ntributing to death but not res	ulting In the u	nderlying cause	given in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?		
						130	Yes 2□No	3 Prob	ably 4 ☐ Unknown		
Completed by						24a. Wes	an autopsy ormed?	ava	re autopsy findings ilable prior to appletion of cause eath?		
dwo						10	Yes zho		Yes 2□ No		
Be C	25. Was case referred to medical				26. Place of De	eath (Check only	1				
To B	examiner?	tospitel: 1 Inpatient 2 I	ER/Outpatier	nt 3 DOA	Wher	Home 5□Res		ner (Specity)		
	27. Manner of Death 1 Neturei 5 □ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	W		28d. Describe	how Injury occur	red			
Certification:	2 Accident investigation 3 Sulcide 6 Could not be	and District 11			☐ Yes 2 ☐ No	20f Location	Street and Alimi	ner or Dum	Route Number		
ertifi	4 Homicide determined	28e. Placa of Injury - At he building, etc. (Specif	ome, 1arm, str y)	eet, factory, offic	0		(Street end Numb wn, Stete)	er or Mure	rioute Number,		
edical Ce	29a. Certifying Phy (Check only one) 2 ☐ Medical Example	sician: To the best of my kno ner: On the basis of examine and manner stated.	wiedge, death tion and/or Inv	n occurred at the vestigation, in my	time, date and place opinion, death occ	ee, and due to the curred at the time,	cause(s) end made dete and place,	anner as sta and due to	ated. the cause(s)		
Me	29b. Signature and title of cartifier	1		29c. Lice	nse number		29d. Date signe	d (Month, L	Dey, Year)		
	> Rules TR	the man		D	24804		1-2	1-99	2		
	30. Name and address of person who	propleted cause of death (Item	n 23a) (Type,	Print)	1		. ^				
	600 Rds	ely tre 1	nnap	odes Me	2140	(ROBER	T PETER	SON M	, D .		
	31. Date filed (Month, Day, Year)	32/ Registrar's Signa	- 1								



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			Certif	ficate of	Death	R	eg. No. 99	02766	
hysician /Medical	1. Decedent's Name (First, Middle, L	Baus		TO SE		2. Date of Deal	PG 19	Year 6:20 ph	
xaminer neral	249-54-5812	Ve street and number) Medical Ce Sex 7. Age (In yrs. Ia	or owniony/	Under 1 Year lonths Days	4b. City, Town, o Annap If Under 24 Hr Hours Min	O. Date of Dirti	HAME Year) 1935 S	4 / /	
unt be notified at ral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A	10c. City,	Town or Locali	on Edgewat	ter			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
al Director	10e. Street and Number 856 Annapolis Ave	enue		10f. Zip Code	1037	1	0g. Citizen of W USA	hat Country?	
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		37	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- irto Rican, etc.)		- American Indian, K, White, etc. White	
Completed	15. Decedent's 8 (Specify only highest gi	ducation rade completed)	16a. Decedent	's Usual Occup	ation during most of w	orking	16b. Kind of Bus	siness/Industry	
ğ	Elementary/Secondary (0-12)	College (1-4or 5+) 4 VTS •	Teach		1)		Educati	on	
To Be Co	17. Father's Name (First, Middle, Las		1000			ame (First, Middle, I	Maiden Surname		
9	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing A	ddress (Street	and Number or F	Rural Route Number	, City or Town,	State, Zip Code)	
	Donald E. Baus, S 20a. Method of Disposition 1\(\text{LOBurial}\) 2 \(\text{Cremation}\) 3 (4 \(\text{Donation}\) 5 \(\text{Other}\) (Specifical)	20b. Pla Cer Removal from State	ce of Disposition	on (Name of bry or other place	>8)		20c. Location - (037 City or Town, State is, Maryland	
	21. Signature of Funeral Service Lice		Geor 2973	Solome	Kalas Fu ons Isla	neral Hom	gewater		
	23a. Part1. Enter the disease, or conshock, or heart tailure. List only	one cause on each line.	Do not enter tr	ne mode or dyin	ig, such as caroli	ac or respiratory arr	est,	Approximate Interval Between Onset and Death	
ner	one hour								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
Ligardian	Part II. Other significant conditions	d.	en in Part I	23h Did to	23b. Did tobacco use contribute to the cause of death?				
							Tobacco use contribute to the cause of death Yes 2 No 3 Probably 4 Unknow		
completed by						24a. Was a perform	n autopsy ned?	24b. Were autopsy findings available prior to completion of cause of death?	
						1 🗆 Y	s 200 No	1 Yes 2 No	
2	25. Was case referred to medical examiner?	Hospital:		Oth	oc:	eath (Check only or			
completely filled in by the funeral director. Medical Certification: To Be (1 1 1 Yes 2 No 27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	4 U Nursing	28d. Describe ha	ow injury occurre		
edical Cer	(Check only 2 Medical Exa	nysician: To the best of my know							
Med	29b. Signature and title of certifier Clause Bugs	and manner stated.		29c. Licens	8640	2	9d. Date signed	(Month, Day, Year)	
Top	30. Name and distinge of person who	completed cause of death (Item)	(Type, Prin	0 210	132 Je	effrey Br	iggs, M.	D.	
State strar	31. Date filed (Month, Day, Year)	1999 32. Recultrar's Signatu	· b.	Soon	61				



Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

ASP Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day 1999 JANUARY **Physician** 1715 P Ivan Paul Bowser /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.O. BOX 402, Friendsville Rd. ROUTE#42 FRIENDSVILLE GARRETT 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 216-22-6443 Director Aug 8, 1925 Maryland Usual Residence of Decedent 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits ahow 1 ☐ Yes 2 No Director 28a-4 MD Garrett Friendsville 4 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Nems 23s or 12063 Friendsville Rd. 21531 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 72 hours after 120 Yes 2 No If Yes, Give Year or Dates: WW 2 1 Never Married 2 Married "natural", or 1 Yes 2 No Specify: p 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 th Carpenter Carpentry permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Importants if Nem 27 is mented other any Injury or other to-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 88 Robert Earl Bowser Naomi Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold L. Bowser/brother 1601 Friendsville-Addison Rd., Friendsville, MD 21531 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Country Side Crem. Jan. 20,99 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A., P.O. Box 275 Eumau seci 179 Miller St., Grantsville, MD e, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, List only one cause on each line. 23a. Part1. Enter the shock, or heart to Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physicien and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical in death) Last Due to (or es e consequence of) resulting in de Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 40 Unknown P 24b. Were autopsy findings svailable prior to completion of cause of death? been si 248. Wes en eutopsy performed? Completed Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 tXXYes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Yown, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 100 of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E JANUARY 20, 1999 nes who completed cause of death Item 23a) (Type, Print) GHIVA 30. Name and address of person HEUDO RE 111 Penn Street, Baltimore, Maryland 21201 filed (Month, Day, Year) Registrar's Signature State JAN 2:2 1999

DHMH 16 Rev 6/95

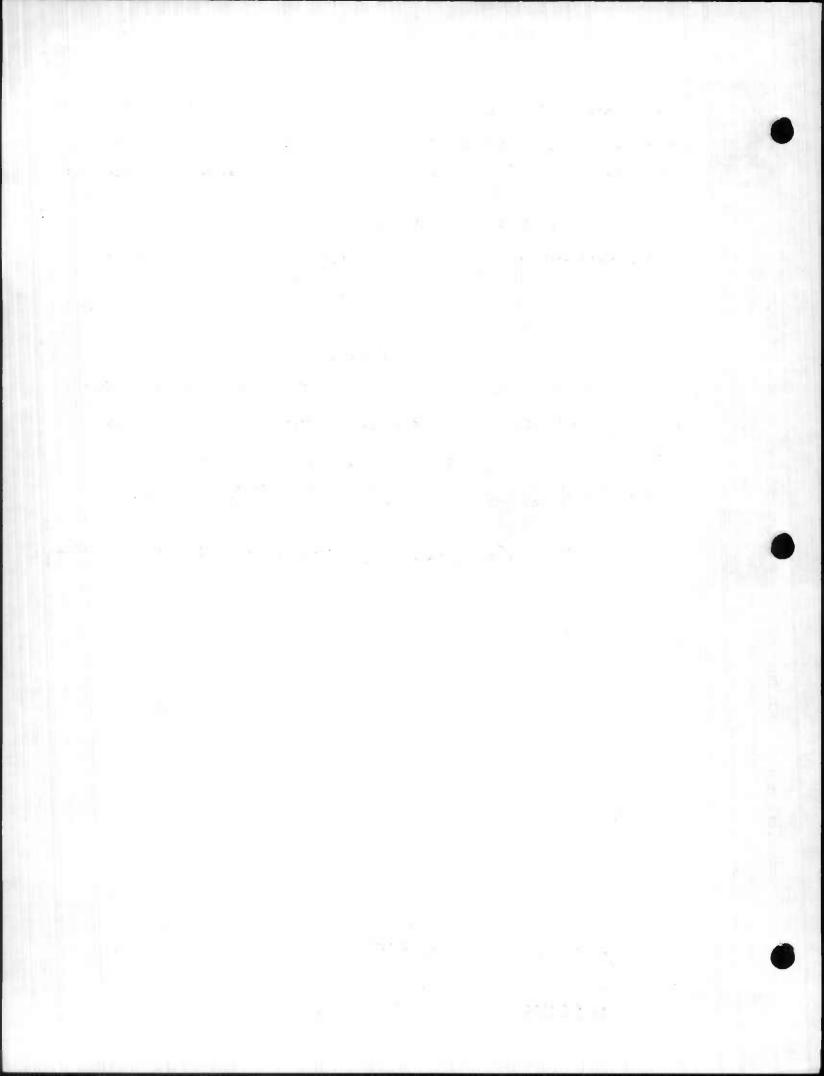
Registrar

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State of Maryland / Department of Health and Mental Hygiene

		Ce	rtificate of Death	Re	g. No.	12/68
	Decedent's Name (First, Middle, Last)			2. Dete of Death	Dey Yeer	3. Time of Deeth
Physiciar /Medica	Edna Mae BITTI	INGER			16, 1999	1:40 AM
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Funeral	5. Sociel Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Deys Hours Min		Year) 9. Birth	plece (Stete or Foreign intry)
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Mar A	MD Garret	t Oaklar	nd			1 ☐ Yes 2 🔀 No
or 28a-f s	10e. Street end Number		10f. Zlp Code	10	g. Citizen of Whet Cou	intry?
3a o	15676 Garrett Highway		21550		U.S.A	
r thems 23s	11 Marital Status 12. Was	Decedent Ever In U.S. 13.	Wes Decedent of Hispenic Origin? (S If Yes, specify Cuben, Mexican, Puer	Specify Yes or No-	14. Race - Amer	Ican Indien,
0 0 5	1 Never Merried 2 Married 1 H	ed Forces? Yes 2(X)No es, Give r or Dates:	1 ☐ Yes 2 💢 No Specify:	to Hican, etc.)	Bleck, White Specify:	
n 72 hours natural,	15. Decedent's Education		dent's Usual Occupation	1	6b. Kind of Business/li	White
	(Specify only highest grade compl	eted) (Give	kind of work done during most of wo DO NOT use retired)	orking	op. rand of Education	ladony
iene. Than *	Elementary/Secondary (0-12) Coll 7th	ege (1-4or 5+)	House Wife		Home	
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should be and Menta and Me	19e. Informent's Neme/Reletionship (Type, Prin		ing Address (Street end Number or A			
0 0 0 0						<i>p</i> 0000)
	Alice Gaither/ Daughte	er 156/6	Garrett Highway		0c. Location - City or T	'own State
ges 1 en it of Heal If item 2 or other	1 X Buriel 2 Cremetion 3 Remove	from State cometery, cre	osition (Neme of metary or other place)			
ment:	4 Donetion 5 Other (Specify)			1/19/99 S	wanton, Ma	ryland
permit. Pages 1 er Department of Hea Important: If item 2 any injury or other once.	21. Signature of Funerel Service Licensee	_ \	2. Name end Address of Fecility Stewart Funeral H		NO 01550	
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at the death certil d by the attending stached for use e	Part tf. Other significant conditions contributing	g to death but not resulting in the u	inderlying cause given in Part f.	23b. Did tol	pacco use contribute	to the cause of death
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The law requires that the do tate has been signed by the page 2 should be datached that the physical p				24e. Wes en perform	ed?	Vere eutopsy findings weiteble prior to completion of cause
has b					ŏ	deeth?
The la				1□ Ye	s 2 🕅 No 1	☐ Yes 2☐ No
ician: The	25. Was case referred to medical		26. Plece of De	eth (Check only one)	
Physician: this certific ral director,	exeminer? 1 Yes 2 No Hospitei	1 ☑ Inpatient 2 ☐ ER/Outpetie	nt 3□ DOA Other: 4□ Nursing	Home 5 ☐ Resider	nce 6 Other (Spec	ity)
g Ph er thi		Dete of Injury (Month, Dey Year) 28b. Time of Injury	of 28c. Injury et Work?	28d. Describe ho	w injury occurred	
Attending For death. Sector: After by the funer fillication.	1 X Neturei 5 ☐ Pending 2 ☐ Accident investigation	(Moriti, Day rear)	M 1 Yes 2 No			
tal or Attending P is after death. al Director: After t led in by the funer. Certification.	3 Suicide 6 Could not be determined 28e.	Ptece of Injury - At home, farm, st	reet, fectory, office		eet end Number or Ru	rel Route Number,
din din	4 Homicide	building, etc. (Specify)		City or Town,	3(8(8)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director, Madical Cartification: To Re 6	(Check only 2 Medical Examiner: On	the basis of examinetion end/or in	h occurred at the time, date and piec vestigation, in my opinion, death occ			
thin 2 thin 2 mple	\wedge	I menner steted.	200 Lineage averbas		M Data signed (84)	Day Vees
Vition To	29b. Signature and title of certifier	to willy	29c. License number	29	d. Dete signed (Month	, Dey, 1881)
	· Vans	1 Julios	H26154		1/19/9	9
2	30. Neme and address of person who completed	cause of deeth (Item 23e) (Type,				
2	Dr. Paul D. Miller	69 Wolf	Acres Dr., Oakla	nd, MD 21	550	
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Signeture	1			
Dogiotror	PPPI C MAI	17	ACA H /			

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** HERBERT LEWIS BALL, JR. January 21 1999 0420 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Woods Center Cambridge Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 6. Sex 100 M 2□ F 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 220-28-1836 65 Yrs. Director Jan. 13 1934 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1€ Ves 2 No Dorchester Cambridge Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 414 High St. 21613 **Нет** 23а U.S.A. Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Çuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or 1 Yes -21 No Specify white by Specify. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 belt weaver wire belt mfg. is marked other permit. Peges 1 and 2 should be file Department of Health and Mental Hy Inportant: If I fem 27 is marked other any injury or other traumatic event sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Herbert Ball Lewis Lois Harrison 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Pauline B. Salisbury-sister 121 Washington St., Cambridge MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Green Lawn Cemetery 1-24-1999 Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Netastatic /Medical Immediate Cause (Finel 4 moules disease or condition resulting In deeth) **Examiner** Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): thet initiated events resulting in death) Lest Due to (or as a consequenca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown signed b þ page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2. No 1 Yes 209No certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, t Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No Certification: To 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homleide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D47924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE MD 21613 THANWY MOMAN 10 AURORA 31. Date filed (Month, Day, Yeer) 32. Registrar's Signeture State JAN 2 2 1999 Registrar

DHMH 16 Ray 6/95

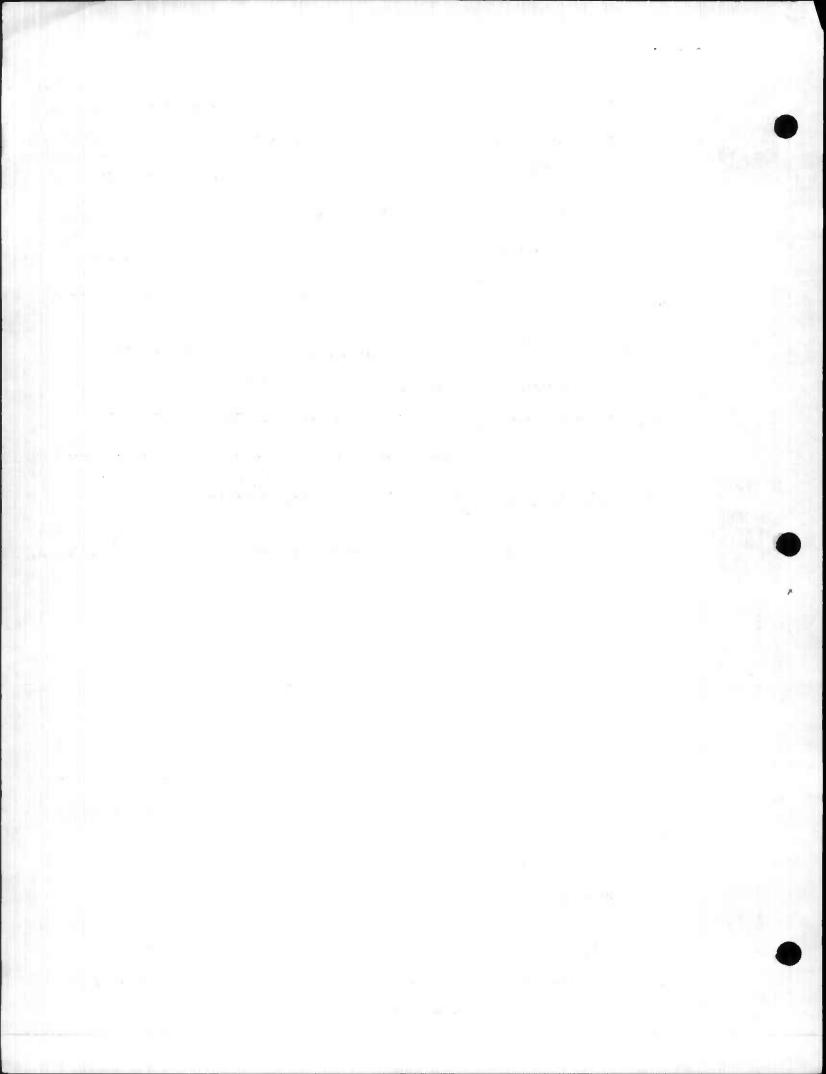
Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

Division of Vital



CIEZOBKA JOSEPHM.

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D. Box 68760,
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Division

	State of Maryland / Department of Health and Certificate of Death		00 00770			
	Decedent's Name (First, Middle, Last)	Reg. I	3. Time of Death			
Physician	JOSEPH M. CIEZOBKA	JANUARY	Doy 1999 12:3000			
/Medical Examiner			4c. County of Death			
Examine	NORTH ARUNDEL HOSPITAL, GIENE	BUENIE AA COUNTY				
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hi		9. Birthplace State or Foreign			
Director	170-28-1991 64 Yrs.	SEPT. 6,19				
P	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits			
father for the father			1 ☐ Yes 2 📉 No			
vith the Ma t or 28a-f s be notified	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Country?			
		U.S	5.A.			
fler death of the flering 23 siner must	11. Meritel Stetus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Mexican, Pue		14. Race - American Indian,			
Och Barbar		mo rican, etc.)	Bleck, White, etc.			
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ylanc wild be fi Mental H writed out	ANDREW CIEZOBKA ELENORA		DOMAT TV			
Maryland d 2 should be file th and Mental Hy 7 is marked oths traumatic event	19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or It		DOMALIK by or Town, Stete, Zip Code)			
_ 5365	NANCY E. CIEZOBKA- (WIFE) 552 WEST COURT, GLEN	I RIIDNTE MZ	ARYLAND 21061			
Or Henry	20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place)		Location - City or Town, State			
Pag nent mit: Il ury o	4 Donetion 5 Other (Specify) MARYLAND VETERANS CEMETER	Y1-22-99 CF	ROWNSVILLE, MD			
Baltimore, semit. Pages 1-a beamment of He reportunit. If the my injury or othe note.	21. Signature of Funerel Service Licensee 22. Name and Address of Facility	INGLETON FI	JNERAL HOME, PA.			
m gorsa	Minhael C. Saffia 1 SECOND AVENUE,					
	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.		Approximate Interval Between			
Physician	1. (1		Onset and Deeth			
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) a. ASSI FOR		(renedulto.			
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8760, sate be executed shysician and the burial-transit	Cause (Disease or Injury that initiated events Due to (or as a consequence of):					
Geath certificate at the standing place of the season of t	d.					
P.O. BOX 68 hat the death certificated by the attending pleated for use as the physician/Mec	Part If. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobac	co use contribute to the cause of death?			
IS, P.O. BOX 6 ss that the death certific graed by the attending p be detached for use as by Physician/Me	Alcold some	1 Yea	2 No 3 Probably 4 Unknown			
dS, signe dbedd by			stopsy 24b. Were autopsy findings			
O required hould		24a. Was an au performed	? evailable prior to completion of cause			
The law life has begge 2 s			of death?			
Vital I		1 ☐ Yes	2 No 1 Yes 2 No			
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Division c tal or Attending P its after death. al Director: After it led in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office	28f. Location (Street City or Town, Str	end Number or Rural Route Number,			
Cer al Direction	4 Homicide building, etc. (Specify)	CRY OF TOWN, SR	510/			
Division of Vital Ra To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate in completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only Medical Examiner: On the best of my knowledge, death occurred et the time, date end plat (Check only Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occ	ce, end due to the ceuse	e(s) and manner es stated.			
the Hospi thin 24 hours the Funer impletely file	one) and manner stated.	-				
5 5 5 5	29b. Signature and fittle of certifier	290.1	Date/signed (Month, Day, Year)			
	augging goyalm my misco 66/	1	14/15			
	30. Name and abdress of person who competed cause of death (from ada) (Type, Print) 7 8 4 0 0 Alleston Nevos 6/04 Aum 4 14	27606				
State	31. Date-filed (Month, Dev. Year) 32. Begisfrar's Signature	2 - 6 /				
Registrar	1414 JAN 2 1 1999 Denve B. Sparke					
	7					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ebris vi.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Data of Death Dey 8 1 Month **Physician** harles William Chane January /Medical 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth 4ja. City, Town, or Location of Death Examiner altimore Hopkins Hospital Johns If Under 24 Hrs. 6. Data of Birth (Month, Dey, Year) Hilloder 1 Yea 7. Age (In yrs. last birthday) 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 2□ F 58 Director August 8, 1940 Maryland 212-36-6428 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 Yes 2 XNo Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ঠ **Ветв** 23a 544 Stoney Hill Ct. 21113 S. A. 14. Rece - American Indian. 12. Wes Decedant Evar in U.S. Armed Forces? 1. Yas 2 \(\) No If Yes, Give Yeer or Detes: 1958-1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status Bleck, White, etc. 1 ☐ Nevar Married 2 ☑ Married 'natural', or 1 Yes 2 No Specify: Specify P 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Ammunitian Handler Civil Service marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If flem 27 is marked otherny injury or other treumstic event pace. Be To Marvin Chaney Ethel Hood 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Paulette Chaney (Wife) 544 Stoney Hill Ct. Odenton. Maryland 21113 20c. Location - City or Town, Stete 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 1 X Muriel 2 ☐ Cremation 3 ☐ Removel from State 1633 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veteran Cemetery Crownsville, Maryland 21. Signature of Funerel Service Licenses 22. Neme end Address of Facility Singleton Funeral Home PA 1 Second Avenue S.W. Glen Burnie, Maryland 21061 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner icien and buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of) physicien a 5 fa Physician/Medicai Dua to (or as a consequence of): esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yea 2 No 3 □ Probably 4 □ Unknown been signed be should be deta by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed page 2 s 1 Yas 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Neturel deeth. 1 Tyes 2 No within 24 hours after deeth. To the Funerel Director: A completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

the death certificate be executed Box 68760 P.O. Records, Division of Vital or Attending Physician: the Hospital

72 hours after

Baltimore, Maryland 21215-0020

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Dete filed (Month, Dey, Year) JAN 2 1 1999

30. Name and oddress of person who completed cause of deeth (Item 23a) (Type, Print)

Fea ther hill 8202 32. Registrer's Signeture

Road, Perry Hall, MD

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

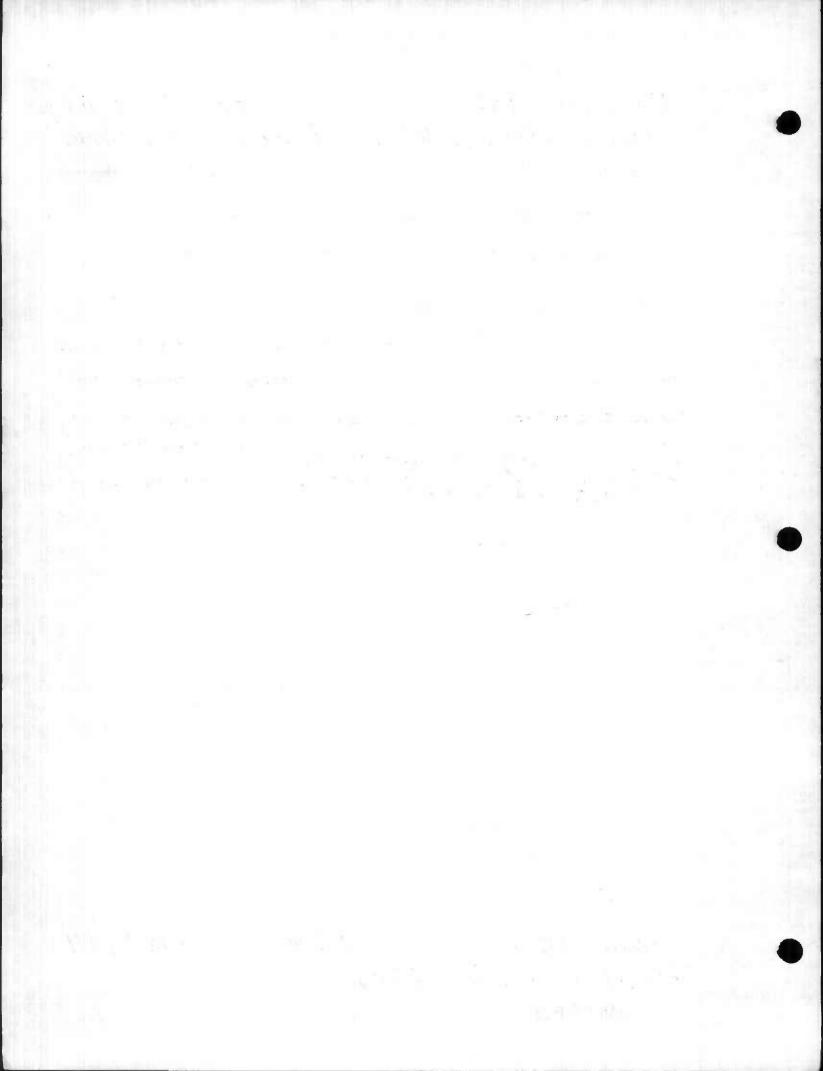
29c. Licensa number

RES-000

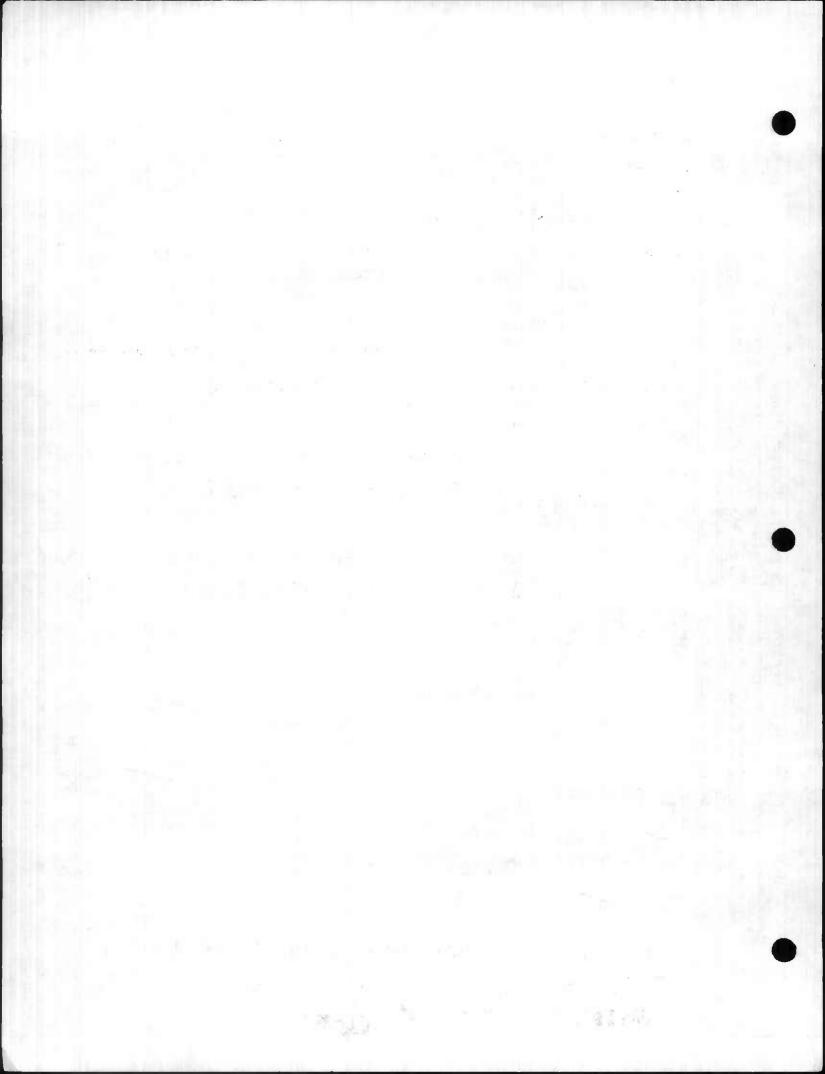
29d. Data signed (Month, Day, Year)

Registrar

Amend.	9	1/20/99 SM AACO E				of Health are of Death		giene 9 9	02772	
Physicia /Medica	al	1. Decedent's Neme (First, Middle, Las Nan Cy Leo	Collins			Ab Cibe Tour	2. Date of De	18 19	3. Time of Death 1:16 pm	
Examine	er	4a. Facility Neme (If ot Institution, give 2708 Summe) 5. Social Security Number 6. S.	Wiew Way	# d	204 If Under	Anno	n, or Location of Deeti 20015 VHrs. 8. Dete of Bir	Anne	Arundel	
Funeral Director		227-52-2646 1 Usual Residence of Decedent	Ом 215 г	57 Yrs.	Months	Days Hours	May 3,	1941	9. Birthpleograficate or Foreign Country III SINIA VIII SINIA	
inyland show		10a. State 10b. County		City, Town or					10d. Inside City Limits	
ath with the Marylan 23a or 28a-f show	Director	MD Anne Ar	rundel Annapolis					10g. Citizen of Wh	1 Yes 20 No	
3a or								et Country?		
Her de	by Funeral	11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	U,S. 13		ent of Hispanic Origin ify Cuban, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)		American Indian, White, etc. White	
21215-0020 d within 72 hours af plene. rr than "naturaf", or rr Medical Exer-	Completed	15. Decedent's Ed (Specify only highest grad	lucation de com <i>pleted)</i>	16a. Dec	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			16b. Kind of Busi	ness/Industry	
and 2121 be filed within tel Hyglene. d other than **	mo:	Elementery/Secondery (0-12)	College (1-4or 5+)	Ex	ecutiv	e Assista	nt	State G	overnment	
T Se H	To Be	17. Father's Name (First, Middle, Last) George Swale					Name (First, Middle,	Meiden Sumeme Seller		
ore, Mar ss 1 end 2 sh of Heelth and itam 27 is m other traum		19a. Informent's Neme/Relationship (7 Terrance Collins	*****				or Rural Route Numb #204, Anr			
		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removel from State	Place of Dis	pe of Dete Jan 22 Crownsville, MD metery 1999					
Baltimo		21. Signature of Funeral Service Open	1 11.00		Name and arranc	Address of Fecility	P.A. Seve	erna Park	Funeral Home	
	4	Ann Ent the disease, or m shock, or heert feilure. List by	acations that caused the de	eth. Do not e	95 Gov inter the mode	Ritchie of dylng, auch as ca	Hwy., Sev	rest,	k, MD 21146 Approximate	
Physician /Medical Examiner	1	Immediate Cause (Final disease or condition resetting in death)	COYONQ Due to						Interval Between Onset and Deeth UNKNOUM	
3 7			b. hyperte	USION	equertée of):					
8760, cata be executed ohysician and the burist-transit	Exam	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and a second cause)	() Due to							
0 = = 0	Medical	that initiated events resulting in death) Last	Due to (or as a consequence of):							
Box 6 death certific attending p	Ician	Dog II. Other significant conditions of					005 014			
P.O	by Physician/M	Pert il. Other significant conditions co	ntributing to death but not r	esuting in the	underlying ca	use given in Part I.			ibute to the cause of death? ☐ Probably 4 ☑ Unknown	
Records, P	Completed							an autopsy	24b. Were autopsy findings available prior to completion of cause of death?	
= F # d	50						10	res 2 No	1 Yes 2 No	
2 3 2	o ne	25. Was case referred to medical examiner?	Hospitel:			Other:	Death (Check only)			
P the selection of	- 1	27. Manner of Death	1 ☐ inpatient 2 26a. Date of Injury	☐ ER/Outpati 28b. Time		A 4	ing Home 5 PResident Properties 1	dence 6 Other now injury occurred		
Vision Attending I r death. ector: After by the funer	Satio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	injury	м	Work? 1 ☐ Yes 2 ☐ No				
	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, : cify)	street, factory,	offica	28f. Location (: City or Tou	Street end Number vn, Stete)	or Rukal Route Number,	
Hospital 24 hours Funeral iletaly filled	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my ki iner: On the basis of exami end manner stated.	nowledge, deanation end/or	ath occurred a investigation, I	t the time, dete and p in my opinion, deeth	place, and due to the occurred at the time,	cause(a) and manr date and place, an	ner as stated. d due to the cause(a)	
To the within 2 To the comple	Me	29b. Signeture and title of certifier	WIN W		29c.	D 28640		29d. Date signed (Month, Day, Year)	
		30. Name and videess of person who d	ompleted cause of death (It	em 23a) (Type	e, Print)	Jeffrey	Briggs, M	.D.	1-11/11	
State		31. Date filed (Month, Dey, Year)	32. Registrar's Sig	neture	ACUIA		·	-		



		4 Danadania M	o Frank & Marie .	1	- Filar y ici		rtificate of	Death		Reg. No.	9 (12773	
Physi	cian	THE WAY TO SHARE	e (First, Middle, La						2. Date of De Month	Day	Year	3. Time of Death	
/Med		4a Facility Name (F. Carro		harl			4b. City, Town, or L		16, 1999	y of Death	1:05 PM	
Exam	iner	407 Shore		o stroot and norm	,,,			Edgewater		Anne		101	
Funera Directo											place (State or Foreign		
ylend		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside			
72 hours after death with the Maryland natural", or forms 23s or 28s4 show deal Estandar must be notified at the death of the part of the death of t	ctor	Maryland	Anne Aru	ındel	Ed	gewate	r					1 ☐ Yes 2 ☐ No	
	Dire	10e. Street and Nu					10f. Zip Code			10g. Citizen of What Country?		ntry?	
		407 Shor	e Drive	140 W D		10 10	21037	Manager College (Co.		United			
OZO ours after de air, or item Exeminence	by Funeral	11. Merital Stetus 1 ☐ Never Marr 3 ☐ Widowed	ied 2 Merried	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? PNo	J,S. 13.	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecity yes of No Pican, etc.)		ce - Americ ock, White, fy: White	etc.	
Maryland 21215-UU20 d 2 should be filed within 72 hours af th end Mental Hygiene. 7 is merked other than *netural; or traumetic evant, the Medical Exem	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		lor 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			king	16b. Kind of Business/Industry				
Hygier the true the true true true true true true true tru		17 Enthada Nama	/First Middle Leet	+1		Vice I	President		o /First Middle	Telecom	-	ations	
Viand ould be file Mental Hy sirked othe	Be C		(First, Middle, Last) . Carroll					Elinor N	ne (First, Middle, Maiden Sumame)				
2 should end Menia is merke	To	George F. Carroll, Sr. Elinor! 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or R											
CENE		Katherine			er)		1000	ve, Edgev					
of Heal		20a. Mathod of Dis			206.				Dete	20c. Location			
Pages nent of mt: If he iry or o		20a. Mathod of Disposition 1 Burial 2 Coremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of ceremetery, crematory or other place) We tropolitan Crematory 01/18/99 Alexandria								ria,	Virginia		
Baltimore, permit. Pages 1 a Department of Her important: If Nem.		21. Signature of Fu	neral Service Licer	m 3	cle			ass of Facility Joh of Glouces				Home,Inc. D 21401	
Physician /Medica Examine	1	23a. Pert1. Entar t shock, or hea Immediata Cause disease or condition resulting in death)	(Finat	10.4	osed the deach lina.	1	ter the mode of dy	fing, such es cardiec	or respiretory e	errast,	1	Approximata Intervel Between Onset end Deeth	
		resulting in obatily			Due to (or as a conse	quence of):	~	N -		1	V	
ored J nnsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							VISEN	se	-	117	
on end	Exa									1			
icata be exacuted physicien end s the burial-transit	dicai									-			
	-	resulting in osatri)	Last	d									
death certi	Iclan	Part II Other elanii	icant conditions o	contribution to doe	th but not en	sulting in the s	andortring course o	iven in Red I	22h Did	tohacco use o	ontribute t	o the cause of death?	
detache	by Physician/M	raitii. Odler signii	art II. Other significant conditions confributing to death but not resulting in the underlying of					Wen in Pen I.	Old tobacco use contribute to the cause of death? Days 2 No 3 Probably 4 Unknow				
requir been s should	Completed b						100			s an autopsy ormed?	av	are autopsy findings eilable prior to empletion of cause death?	
The lew ata has page 2	mo:								10	Yes 20 No	11	☐ Yes 2☐ No	
	Be	25. Was casa refer	red to medicat					26. Place of Dea	ith (Check only	one)			
OT VICE Physician: rithis certific rial director,	10	1 Yes 2 €	No	Hospitel: 1 Inj	patient 2	ER/Outpatie	nt 3 DOA O	ther: 4 Nursing H	ome 5 Mas	idence 6 □Ot	her (Specia	(y)	
	on:	27. Manner of Deat 1 Detatural	5 Pending	28a. Data of (Month,	Day Year)	28b. Time of Injury		ury at ork?	28d. Describe	how injury occu	rred		
deat deat	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be detarmined	9 28a. Place o	f Injury - At h , etc. <i>(Speci</i>	nome, ferm, st	M 1 []Yas 2□No		(Street and Num wn, Stete)	ber or Run	al Route Number,	
To the Hospital or / within 24 hours after To the Funerel Dire completaly filled in b	edical C	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the base and manne	is of examina	owledge, deat ation and/or in	h occurred at tha to exestigation, in my	tima, data and place opinion, deeth occu	, and dua to tha rred et the time,	cause(s) and m date and place	nanner as s , and dua t	stated. the cause(s)	
within To the	×	29b. Signature and	titla of certifier	1 1	, 1	0	29c. Licer	se number		29d. Data sign	ed (Month,	Day, Year)	
		Ing	17Fm	In An	mis	+ Free	hun D	17965	-	1/17	199		
		30. Name and add	ess of person who	completed cause	of death (Ite	m 23a) (Type,	Print)	Dre A	mare li	s. M.	214	01	
	tate	31. Data filed (Mon		32. Reg	istrar's Sign	ature 6	1			7			
Regis	trar	JAN	191999	4	100	D.	1,4000						



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MILDRED NORINE CARSKADON JANUARY 16, 1999 6:06 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death DENNETT ROAD MANOR NURSING HOME OAKLAND GARRETT If Under 24 Hrs. Hours Min. If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 1□M 2ÅF Months Deys 92 NOV. 1, 1906 MARYLAND 10c. City, Town or Location 10d. Insida City Limits 1X Yes 2 No GARRETT OAKLAND 10f. Zip Code 10g. Citizen of What Country? 209 W. LIBERTY STREET 21550 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

723 E. OAK STREET

22. Neme end Address of Fecility

HOMEMAKER

20b. Placa of Disposition (Name of cemetery, crematory or other place)

TERRA ALTA CEMETERY

with the Marylend 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner natatible noutled at death filed within 72 hours after Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral

Director

5. Social Security Number

215-42-4732

10e. Street and Number

11. Maritel Status

10a, State

Director

à

Usual Residence of Decedant

3 ☑ Widowed 4 ☐ Divorced

Eiamantary/Secondary (0-12)

10b. County

15. Decedent's Education (Specify only highest grade completed)

Year or Dates:

Coilege (1-4or 5+)

KNOTTS

al Hygiene. 12 should be fi n end Mental H is marked ou permit. Peges 1 end 2 sh Department of Heelth end Important: If Item 27 Is m any injury or other traum 2002e.

Physician /Medical **Examiner**

attending physician end for use es the buriel-transit certificete be exect the a à signed t peen certificate hes funeral Ne Hospital or Attanding Ph n 24 hours after death. Ne Funeral Director: After th the

Box 68760,

P.O.

Records,

Division of Vital

Examiner Physician/Medical by Completed Be 10

Certification:

Completed 17. Father's Name (First, Middle, Last) Be GEORGE LAWSON 19a. informant's Name/Relationship (Type, Print) JOAN FIKE - DAUGHTER 20e. Method of Disposition 1 Burlal 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licepsee immediate Causa (Final disease or condition rasulting in daath)

M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failura. List only one cause on each lina. Approximate Interval Between Onset and Deeth ALZHEIMER'S DISEASE Syears Due to (or as a consequanca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case refarred to medical examiner? 26. Placa of Death (Check only ona) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Mannar of Death 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 (XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

2

To the Vithin 2

P. DANIEL MILLER, D.O. 31. Date filed (Month, Day, Year)

69 WOLF ACRES DRIVE

OAKLAND, MARYLAND 21550

JANUARY 18, 1999

16b. Kind of Business/Industry

OWN HOME

SHAFFER

20c. Location - City or Town, State

TERRA ALTA, WV

18. Mother's Name (First, Middle, Maiden Sumame)

1/19/99

DAISY

OAKLAND, MARYLAND 21550

P.O. BOX 243

MARGARET

19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)

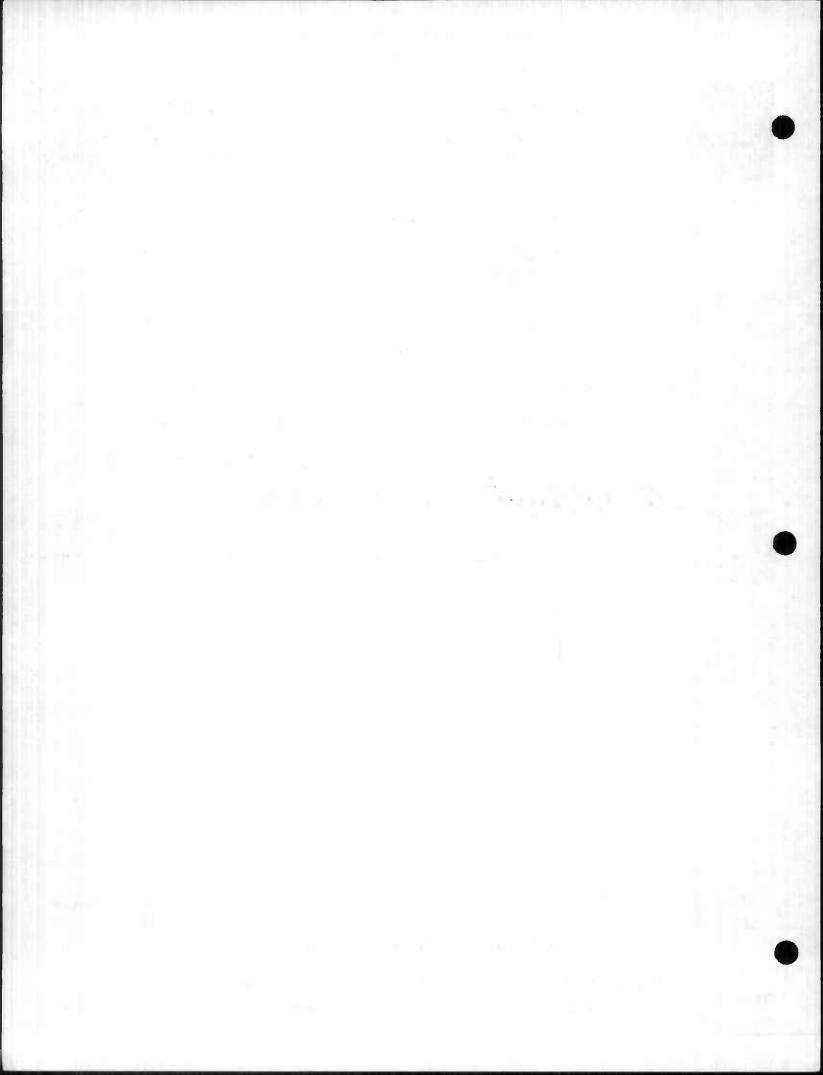
State Registrar **JAN 19**

30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print)





H26154



State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate o	f Death		Reg. No.	3 0	4//5	
	Physic /Medi		Decedent's Neme (First, Middle, La ROSE MARY	st) CIMAGLIA					2. Dete of De Month JANUAR	Dev	999°	3. Time of Deeth 2:10 PM	
	Exami		4e. Fecility Neme (If not institution, given GARRETT COUNTY M	4b. City, Town, OAKLA	or Location of Deet ND	Deeth 4c. County of Deeth GARRETT							
	Funeral Director			7. Age (In yrs. lest birthday Yrs.			If Under 1 Year Months Dey			v. Year)	9. Birthplece (State or Foreign Country) MARYLAND		
	pue *		Usuel Residence of Decedent 10e. Stete 10b. County		10c Ci	ty. Town or Lo	ocation				100	I. Inside City Limits	
	ire, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental hygiene. Item 27 is marked other than "natural", or items 23s or 28s4 show other treumatic avent, the Medical Evant rectinal be notified at	ctor									100	1 XYas 2 No	
		al Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Code 4510 WOODLEA AVENUE UNKnown USA									п	
020		by Funeral Director	11. Marital Status 1 □ Navar Married 2 □ Married 3 □ Widowed 4 ☒Divorced	Armed Ford 1 ☐ Yas 2 If Yes, Give	Wes Decedent Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Detes: 13. Was Dacedent of Hispanic Origin? (Sp If Yes, specify Cuben, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:			(Specify Yes or No erto Rican, etc.)	14. Rac Ble	ce - Amarican ck, White, etc	0.		
1215-0		Completed	15. Decedent's E. (Specify only highest green terry/Secondery (0-12)	ducation eda completed) College (1-4	4or 5+)	(Give	Decedent's Usuel Occupetion (Give kind of work done during most of work life. DO NOT use retired)						
		To Be Co	17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surne										
Maryland	nd 2 should be Ith end Mental IT is marked of treumatic av	-	19e. informent's Neme/Reletionship (Type, Print)			ng Address <i>(Str</i> e	et end Number or	Rural Route Numb	er, City or Town	, Stete, Zip C	Stete, Zip Code)	
Baltimore,			20e. Method of Disposition 1 Buriel 2 🛱 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Neme of camerory, cremetory or other placa) OMEGA CREMATORY 1/15/99 MORGANTO								- City or Town	City or Town, Stete	
Balti	permit. Pege Depertment of Important: If any Injury or		21. Signature of Furrieral Service Licer		MOO	22	2. Name end Add	dress of Fecility		BOX 24	3		
Ñ	Physician /Medical		23a. PartT. Enter the diseese, or com shock, or heart feilure. List only Immediate Cause (Finel	plications thet car one ceuse on ee							A	pproximata htervel Between onset end Deeth	
	Examiner		disease or condition resulting in death)	e. acut		logen		ukemia			1	0 days	
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90,	icate be executed physician and s the bunal-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	CO	ngest	ive h	eart f	ailure			1	yr	
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_	To the Hospital or Attending is within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical Ce			is of exemina				eca, end due to the ecurred et the time,				
	To the within To the comple	M	29b. Signature and title of certifier	DIA	1		29c. Lica	nse number		29d. Date signe		ıy, Year)	

State Registrar

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)



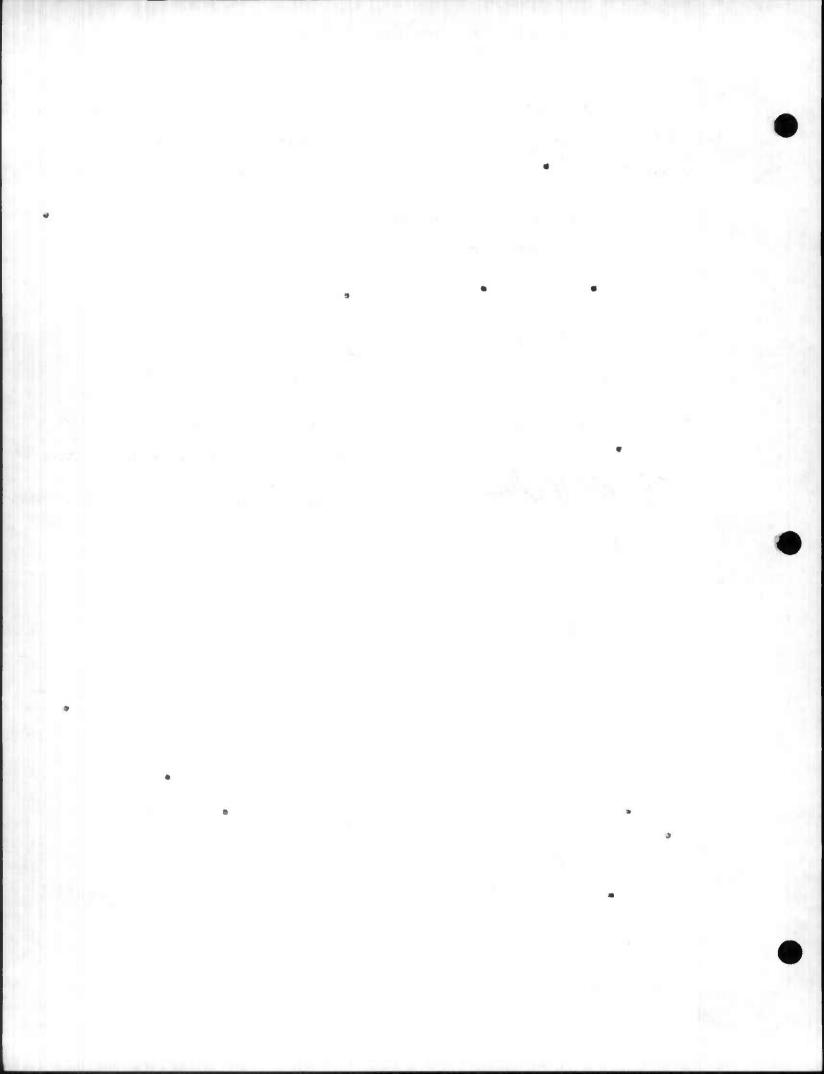


Oakland, MD 21550

State of Maryland / Department of Health and Mental Hygiene 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Data of Death 3. Time of Death Month Day Physician 10:30 p.m. Joseph John Camaioni 13,1999 January /Medicai 4a. Facility Name (If not institution, give straet end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 18575 St. Jerome's Neck Road St. Mary's Dameron If Undar 24 Hrs. 8. Date of Birth Month, Day, Year) June 20, 1922 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year **Funerai** Birthplace (State or Foreign Country) Days Hours 1 ■ M 2 □ F Months 76 216-18-7158 Director Maryland Usual Residence of Decedant with the Maryland 10a. Stete 10b. County 10c. City, Town or Location worle 10d. Inside City Limits 7 la marked other than "natural", or items 23a or 28a-f shor traumstic event, the Medical Examinating the notified at 1 ☐ Yes 2 ■ No Director Maryland St. Mary's Dameron 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 18575 St. Jerome's Neck Road 20628 United States Funeral death 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 11. Marital Status 14. Rece - Amarican Indian permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural". ~ in any injury or other traumatic avant. Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ■ No If Yes, Give 1 ☐ Yes 2 ■ No Specify: à White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Fence Company Owner/Operator 6 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Patsy Camaioni Mary Settimio Lo 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 18575 St. Jerome's Neck Road, Dameron, MD 20628 June H. Camaioni, Wife 20b. Piece of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ■ Cremation 3 ☐ Removal from Stata Metropolitan Crematory 1-17-99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Cheral Brinsfield, Jr., M00052 Edward N. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Pert1. Enter the disease, or complications that ceusad the deeth. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Onset and Death **Physician** /Medicai Immediate Cause (Final disaase or condition resulting in death) Metaslatic COLON CANCER 9 months **Examiner** Due to (or es a consequence of) Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Ceuse (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as e consequence of): physician s the burial Box 68760. Physician/Medical Dua to (or es a consequence of): use as attending for use as the a P.O. Part II. Other aignificent conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? ate has been signed by t page 2 should be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■ Unknown by Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy performed? this certificate 1 ☐ Yes 2 ☐ No I or Attending Physician: after death.

Director: After this certifica Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No funerai 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) end manner steted. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Yeer) 1/14/99 750686 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Gurdeep S. Chhabra, M.D., 25500 Point Lookout Rd., Leonardtown, MD 20650
31. Date filed (Month, Dey, Year)

1 N 1 5 1900 State JAN 1 5 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9

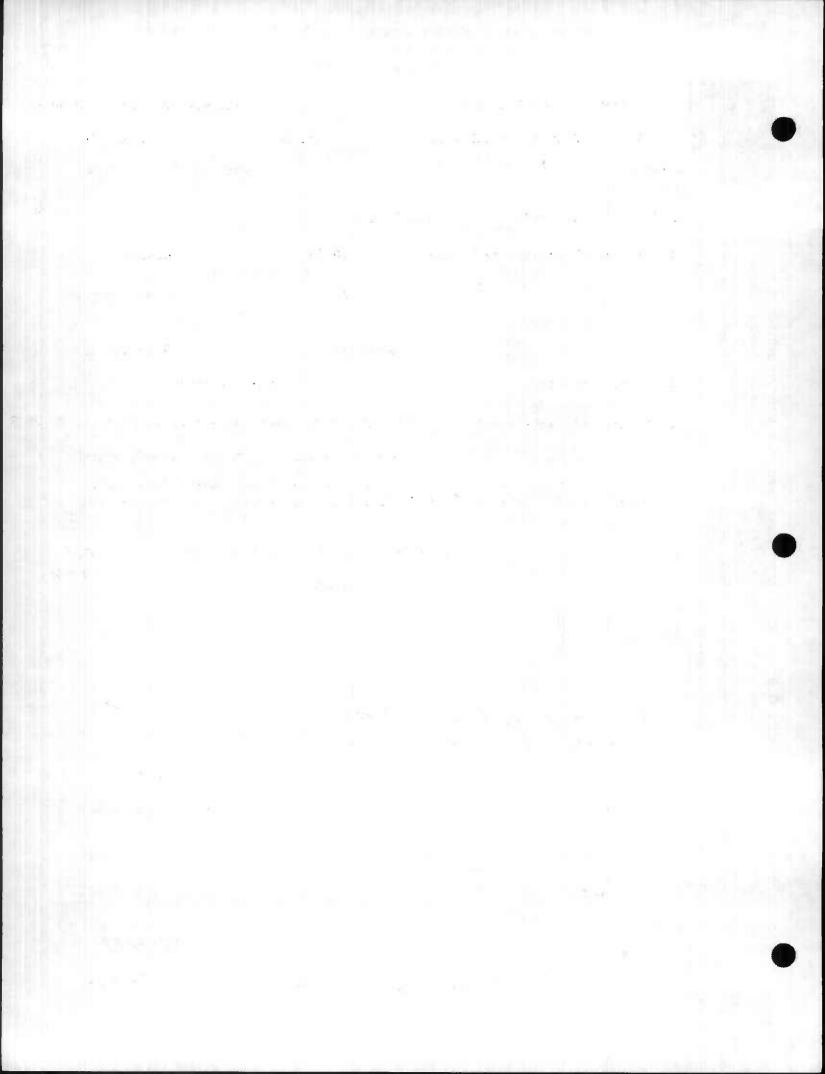
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Joseph Douglas Clements 22, January 1999 2:00 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 23520 South Patuxent Beach Road California St. Mary's | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | (Month, Dey, Yeer) | March 27, 1917 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F 577-22-8085 81 Maryland **Director** Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show 1 Yes 2 No Maryland St. Mary's Directo California 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of health and Mental hygiene.

Int: if item 27 is marked other than "natural", or itema 23a or intro or other traumatic event, the Mental Exampse mail by a river or other traumatic event, the Mental Exampse mail or or other traumatic event, the Mental Exampse mail or or other traumatic event, the Mental Exampse mail or or other traumatic events. 23520 South Patuxent Beach Road 206 19 U.S.A. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Mechanist Auto Supply 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be James F. Clements Ethel G. Newton 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent'a Name/Relationship (Type, Print) Helen Ruth Clements/Spouse 23520 South Patuxent Beach Rd., California, MD 20619 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition

14 Burlel 2 ☐ Cremetion 3 ☐ Removel from State Dete 20c. Location - City or Town, State permit. Page Depertment of Important: If any injury or Trinity Memorial Gardens 1/25/99 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Licansi Mattingley-Gardiner Funeral Home, P.A. Varoliner Lechae P.O. Box 270, Leonardtown, Maryland 20650 23e. Part Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician Metastatic Carrinoma of

Due to (or as a consequence of):

LVNG - Small (cil type) /Medical Immediate Cause (Final disease or condition resulting in death) Examiner 1998. Examiner physician end the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet Initiated events resulting in death) Last Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 88 USB ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3₽ Frobably 4 Unknown (monary Artery siscend à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed (AND NIC Obstricte pulmoner certificate has b lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Dey Yeer) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 DNatural 5 Pending investigation death. 1 Yes 2 No 2 Accident after deati Director: 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) end manner es stated. edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated. within 2 To the complet 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 036206 womest 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLLYWOOD MD 20636. Mchta 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 25 1999 Registra



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Thomas Cecil 23, 1999 4c. County of Deeth **January** 11:00 p.m. 4a. Facility Nema (If not institution, giva street and numbar) 4b. City, Town, or Location of Daath 714 Weybridge Circle Severna Park Anne Arundel If Undar 1 Yaer If Undar 24 Hrs. Birthplace (Stata or Foraign Country) 7. Aga (In yrs. last birthday) Data of Birth (Month, Day, Yaar) Months Days Hours 1 ■ M 2 □ F Yrs. 74 September 26,1924 Maryland 10h County 10c. City, Town or Location 10d. Insida City Limits Anne Arundel 1 MYas 2 No Severna Park 10f. Zip Coda 10g. Citizan of What Country? 714 Weybridge Circle 21146 United States 12. Wes Dacedant Evar in U,S. Armed Forcas? 1 ■ Yas 2 □ No If Yas, Giva Yaar or Dates: WWII Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuben, Mexican, Puarto Ricen, atc.) 14. Race - Amarican Indian Black, White, etc. 1 ☐ Never Married 2 ■ Marriad 1 Yas 2 No Specify: Specify: White 3 ☐ Widowad 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Dacadant's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) Elementary/Sacondary (0-12) Collega (1-4or 5+) Attorney at Law Legal 11 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) John Allan Cecil Rose Emilie Boothe 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) Ann T. Cecil, Wife 714 Weybridge Circle, Severna Park, MD 21146 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ■ Burial 2 □ Cramation 3 □ Ramoval from Stata 1-28-99 Holy Face Cemetery 4 ☐ Donation 5 ☐ Othar (Spacify) Great Mills, Maryland 22. Nama and Address of Fecility Brinsfield Funeral Home, P.A. Brinsfield, Jr., M052 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complicator is that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one course on each line. MALIGNANT MESOTHELIOMA Dua to (or as a consequance of): Dua to (or as a consaquence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy 1 ☐ Yas 2 No 2 NO 25. Was cesa rafarrad to medical 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical Examiner

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P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician:

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within 24 hours efter deat To the Funeral Director:

Physician

/Medical

Examiner

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28a-f ehow

the Medical Examiner must be notified at

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permit. Pages 1 and 2: Department of Health er Important: If Item 27 is any injury or other tra-

Pages 1 and 2 should be

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Funeral

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With 6 items 23a

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Baltimore, Maryland

John

5. Social Sacurity Number

218-30-2812

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Maryland

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10e. Straat and Number

20a. Mathod of Disposition

21. Signatura of Funeral S

Immediata Causa (Final disaasa or condition rasulting in death)

Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated events rasulting in daath) Last

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Physician/Medicai signed by the old be detached to þ Certification: in by

Part II. Other algrificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

28c. Injury at Work?

28d. Dascribe how injury occurred

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29b. Signature end title of certifier

1 Yas 2 No

27. Manner of Daath

2 Accidant

3 Suicida

29a. Cartifier

4 Homicida

1 Cartifying Phyalcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Pending Invastigation

6 Could not ba

29c. License number

1 ☐ Yas 2 ☐ No

29d. Data signad (Month, Day, Year)

death (Itam 23a) (Type, Print)

7401 OSLER DR. SUITE 202 TOWS W/MD 21204 31. Date filed (Month, Day, Yaar)

State Registrar

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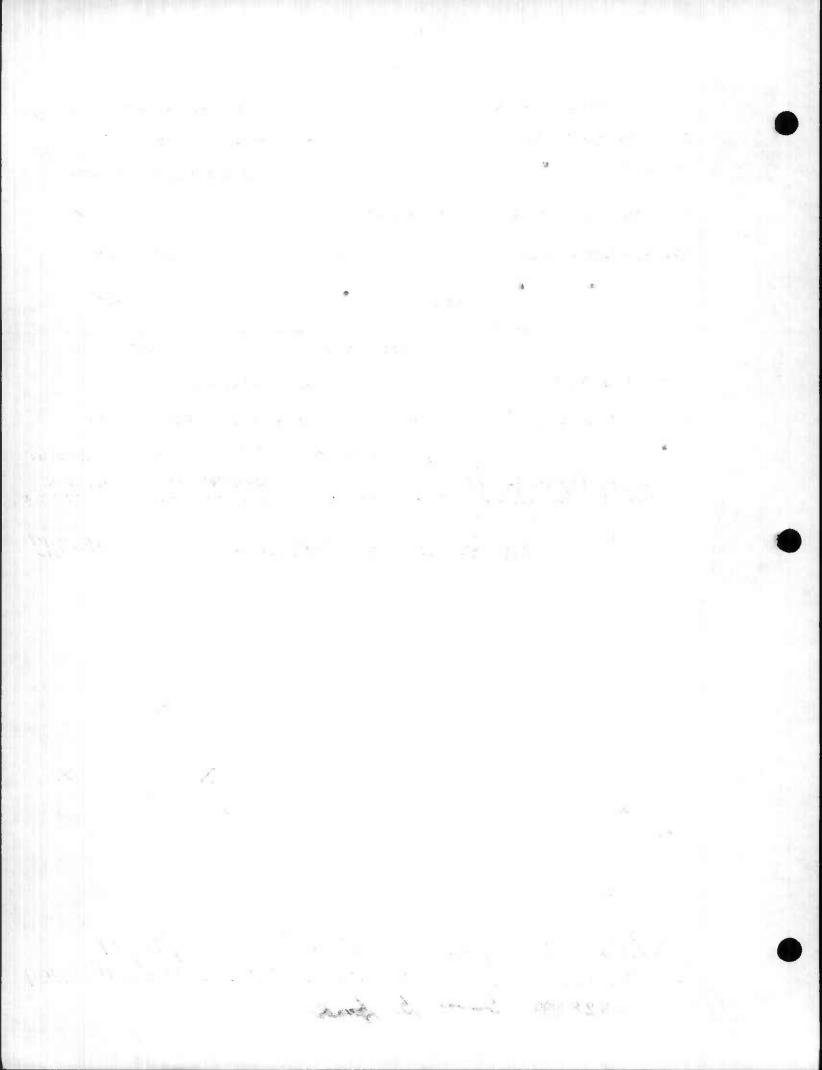


28a. Data of Injury (Month, Day Yaar)

28b. Tima of

Place of Injury - At homa, farm, straet, factory, offica building, atc. (Spacify)





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 0 2 7 7 9

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death Name (First, Middle, Last) 2. Date of Death Jan Donald 76 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give if Under 24 Hrs 7. Age (In yrs. lest birthdey) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) Days Hours 1 M M 2 □ F Months 65 215-32-5503 1933 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 34 McPherson Road 21401 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 11. Maritai Status 1 Yes 2 No If Yes, Give 1 Never Married 27 Married 1 ☐ Yes 2 ♥ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 1953-55 White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Chief Estimator Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Esther Mendell Paul A. Donald 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Donald / Wife 34 McPherson Rd, Annapolis, Maryland 21401 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 to Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland Hillcrest Memorial Gardens 22. Name and Address of Facility ignature of Funeral Service Micensee John M. Taylor Funeral Home Inc

Physician /Medical

Physician

* /Medical

Examiner

10a. State

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examinal must be notified at

Directo

Funeral

þ

Completed

Be

with the Maryland

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than

other

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altimore, Maryland 21215-0020

Examiner

physician and tha burial-tran

signed by the a

page 2 has

director,

funeral

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i or Attending P after death. I Director: After

Hospital 24 hours

To the To the To the I

Be

10

Certification:

Medical

certificate be axec Box 68760

P.O.

Division of Vital Records.

Examiner Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Inflieted events resulting In death) Last Physician/Medical by Completed

2 Accident

3 Suicide

4 - Homicide

Immediate Cause (Final

disease or condition resulting in death)

23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

pertension Due to (or as a consequence of)

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 WUnknown

24a. Was an autopsy performed?

147 Duke of Gloucester St. Annapolis, Md 21401

24b. Were eutopsy findings available prior to completion of cause of death?

one hour

1 ☐ Yes 2 € No

1 Yes 2 No

25. Was ease referred to medical			1	26. Place of Death (C	heck only one)	
examiner?	Hospital:	2 ER/Outpatient	30 DOA	Other: 4 Nursing Home	5 Residenca	8 Other (Specify)

28a. Date of Injury (Month, Day Year) 27. Menner of Death 5 Pending investigation 1 Natural

Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

29a. Certifier (Check only one) 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and matter. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

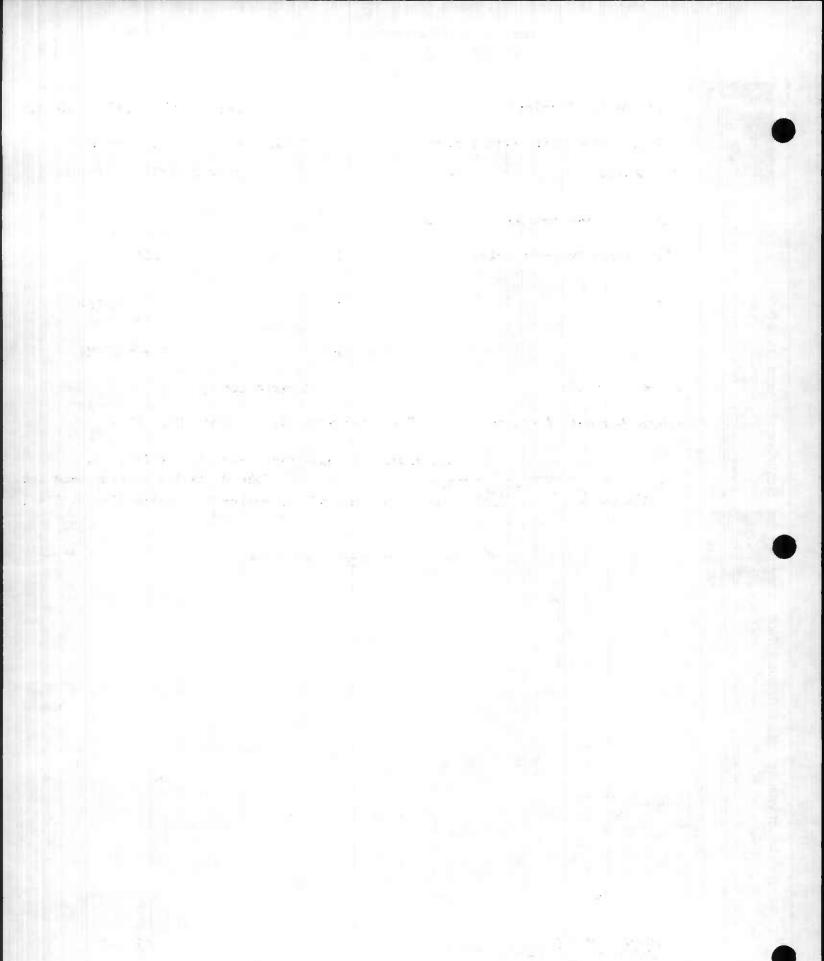
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Mae Lewis Dashiell 15 1999 Jan. 3:10 PM /Medical 4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ginger Cove Health Care Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 20, 1901 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign
Country) **Funeral** Days 1□ M 21XF Months Hours Min. Virginia 97 Yrs. 218-36-9627 **Director** Usual Residence of Decedant the Maryland r 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Directo Md. Anne Arundel Annapolis 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Counfry? with 1 r than "natural", or items 23s or the Modesi Examiner must be r 3303 River Crescent Drive USA 21401 Funeral death 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, Whita, etc. 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Nevar Marriad 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: p White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) al Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) Book keeper State of Md. other traumatic svent, 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Name (First, Middla, Last) 12 should be fill h and Mental H Is marked oth Andrew D. Lewis Roberta Lackey 10 19a. Informant's Nama/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 st Department of Hasilh and Important: If Item 27 is n sny Injury or other traun once. George Hardesty / grandson 1790 Brickhouse Rd. Dunkirk, Md. 20754 altimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State St. James Episcopal Cem. 1-19-99 Lothian, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Lioumne 22. Name and Address of Facility John M, Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Respiratory faclure tmmediate Cause (Final disease or condition resulting in death) /Medical 1 wh **Examiner** Examiner ician and buriel-transit certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequenca of): Box 68760 attending physician Physician/Medical the Due to (or as a consequence of) 60 use a signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, g 24a. Was an autopsy performed? 24b. Wara eutopsy findings available prior fo Completed completion of cause of deeth? has paga 2 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No certificata 25. Was case referred to medical axaminar? director Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Solursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No this 28a. Date of Injury (Month, Day Yaar) funeral 28d. Describe how Injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? Aftar Certification: Attending 1 Matural 5 Pending Investigation i or Attending after deeth. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospitai 24 hours 1 Gardifying Phyercfan: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) To the Within 2 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 130718 1-18-90 Illean del 30. Name and address of person who complated causa of daath (Item 23a) (Type, Print) 2003 lendocal Okery, Lucypolog led 21601 John Joelson, ald 31. Data filed (Month, Day, Year) 2 Registrar's Signature JAN 1 9 1999 Registrar

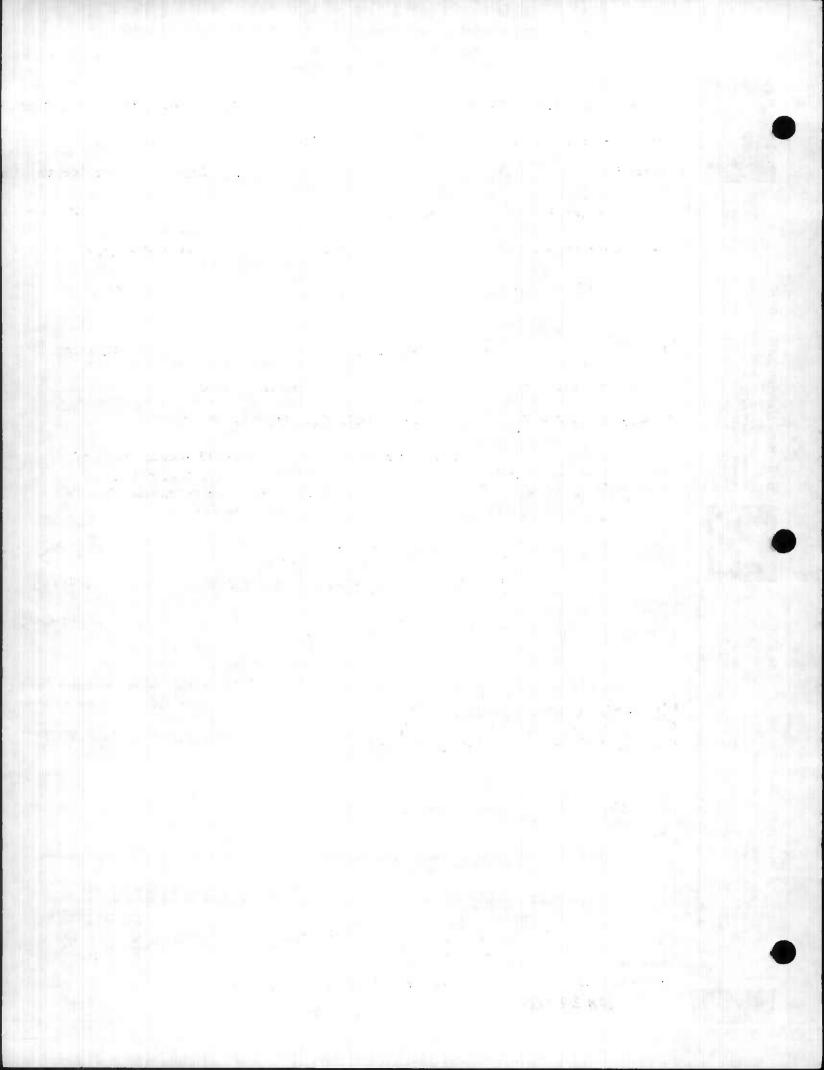


Carl Carlo

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** William Wayne Davis JANUARY 18 1999 04:32 AM /Medical 4a Fecility Name (If not institution, give streat end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Sacred Heart Hospital Cumberland
If Under 24 Hrs. 8 Allegany If Under 1 Year Birthplece (Steta or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Hours Days 10 M 2 F Yrs 70 160-22-5033 Director 12/22/28 Pennsylvania Usual Residenca of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "naturel", or items 23a or 28a-f ahor the Medical Examiner must be notified at WV XXYas 2 No Mineral Director Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 S. Main Street 26726 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 11 Maritai Status Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hyglena. Int: if item 72 is marked other than "naturel; or ite ury or other traumatic event, the Medical Examine. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🔀 No Specify: Specify: White Aq 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 + 12 Minister Churches (Episcopal) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Clair Davis Ruth Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Beverly Davis / Wife 119 S. Main St. Keyser, WV 26726 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata permit. Page Department of Important: If eny Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Philos Cemetery 1/21/99 Westernport, MD 21. Signature of Funeral Servica Licenses 22. Name and Address of Facility 111 Church St. wing Boal Funeral Home Westernport, MD 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Due to (or as a consequence of) Examiner SENSR the death cartificate be executed physician and the burial-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. A200 My opan Physician/Medical use as t ŏ signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 XNo 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s has SKINO 1 ☐ Yes 2 ☐ No certificata director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Inpatiant 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury at Work? Certification: or Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours edicai 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the completaly On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 1 the 29d. Date signed (Month, Day, Year) 29b. Signatura and title of cartifia 29c License number 20 BEXT mesica pood 30. Name and address of person who complete cause of death (Item 23e) (Type, Print) Robert Welik, MD 902 Seton Dr. Cumberland, MD 21502 32. Registrar's Signature 31. Date filed (Month State conta Registrar



Piease Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day Year **Physician** Roy Harrison Dye, Sr. **JANUARY 6 1999** 8:20 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Cumber land Allegany Sacred Heart Hospital If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Mar. 19, 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Year) 1931 Maryland **Funeral** Days 1 № M 2 🗆 F Months Hours Min Yrs. 67 **Director** 215-26-6587 Usual Residence of Deceden Pages 1 end 2 should be filed within 72 hours after deeth with the Marylem nent of Health and Mentel Hygiene. Intent of Health and Mentel Hygiene. Intit if them 27 is marked other than "natural", or them 23 a or 28a-f ahow ury or other traumatic event, in Market. 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County Md Allegany Westernport XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 311 Johnson St. 21562 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Specify: White altimore, Maryland 21215-0020 1 ☐ Yes 2 🕱 No Specify: þ 3 Vidowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver & Painter Self-employed Unknown 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Hester McManus Harrison Dye 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Westernport, MD 311 Johnson St. 21562 Patricia L. Dye 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition p⊠Buriai 2 ☐ Cremation 3 ☐ Removal from Stete permit. Page Department of Important: If any injury or once. 1/9/99 Bloomington, MD Bloomington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 111 Church St. 5 in 21562 Westernport, MD Boal Funeral Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** CARABROVASCULAR ACCIDENT Immediate Cause (Finel diseese or condition resulting in death) /Medical WEEK Examiner Examiner DISTAGE YEARS ARTERIOSCUTROTIC CARDIOVASCULAR attending physician end for use es the bunal-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): P.O. Box 68760. Physician/Medicai Due to (or es e consequence of): 80 use 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown HEART FAILURE signed b Division of Vital Records, þ 24b. Were autopsy findings evaileble prior to 24e. Was en eutopsy performed? Completed completion of cause of deeth? page 2 s has 1 Yes 2 N 1 Yes 20 No certificate 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 JAG 1 Dunpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Certification: After or Attending 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the after deet 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner as stated. within 24 hor To the Fune complately fi edical 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and menner steted. (Check only one)

State

Registrar

31 Date World (Month, Day, Year)

JOSE

JAN 11

29b. Signature and fittle of certifier

30. Name and ad

32. Registrer's Signeture 1999

son who completed cause of deeth (Item 23a) (Type, Print)

PHYSI CLAN

LOVERIA JR.

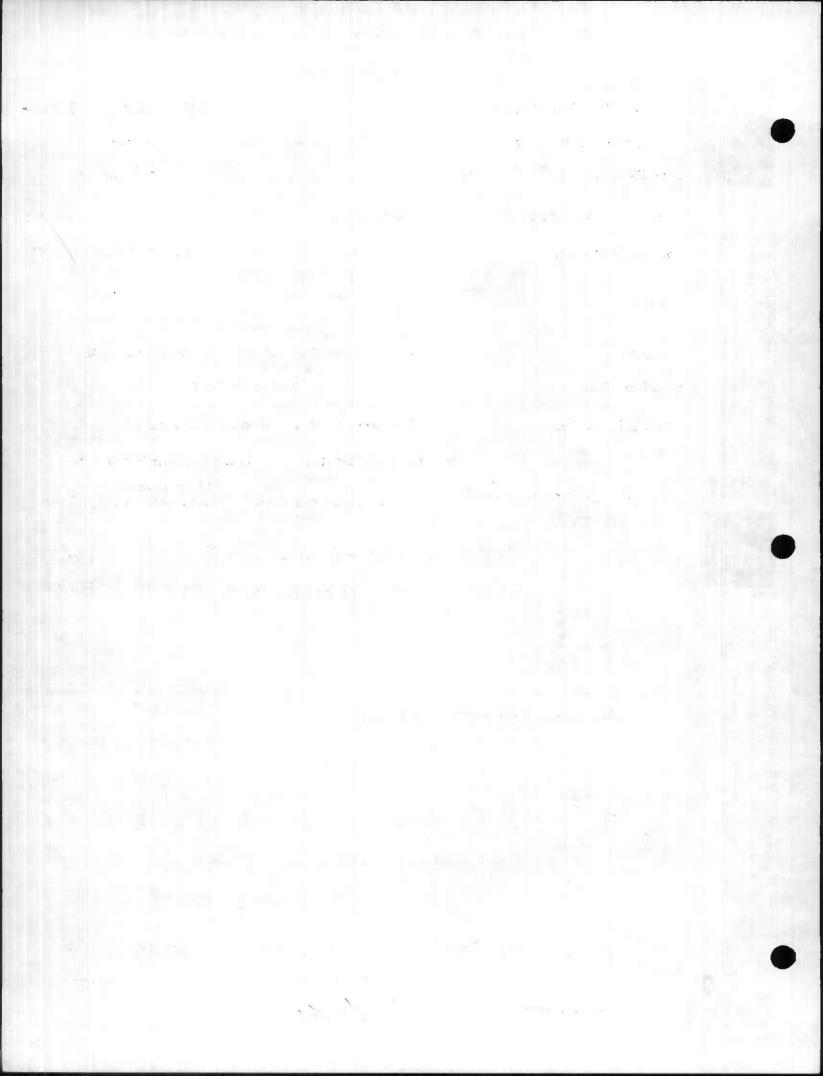
M.D.

29c. License number

29d. Date signed (Month, Day, Year)

JANUARY

912 SETON DRIVE CUMBERLAND, MO 2 1502



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Theodore Hatch Dent, Sr. 12:45 A.M. January 20, 1999 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner St. Mary's Nursing Center Leonardtown St. Mary's | Months | Deys | Hours | Min. | August 15, 1905 | Maryland 5. Sociei Sacurity Number 7. Age (In yrs. lest birthday) Birthpleca (Stete or Foreign Country) **Funeral** 1■ M 2□ F Yrs. 577-10-7103 93 Director Usuel Rasidence of Decedant with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ms 23a or 28a-f short recent be notified a 1 ☐ Yes 2 ■ No Directo Maryland St. Mary's Avenue 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? General Delivery 20609 United States Funeral filed within 72 hours after death items. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Reca - American Indien, the Medical Examiner Bieck. Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yes 2 ■ No If Yas, Give Yeer or Detes: ò 1 ☐ Yes 2 ■ No Specify: þ 3 ■ Widowed 4 □ Divorced Specify. "natural", White Completed 15. Dacedent's Education (Specify only highest grade complated) 18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry mit. Peges 1 and 2 should be filed withir artment of Health and Mental Hygiene. ortant: If item 27 is marked other than Injury or other traumatic event, the Method of the Method or other traumatic event, the Method of the Meth Elementary/Secondery (0-12) Collega (1-4or 5+) Florist Floral Industry Maryland 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Dr. Walter B. Dent Grace Blackistone 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Theodore H. Dent, Jr. Son 6330 Bryantown Drive, Bryantown, MD 20617 Baltimore, 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stata 1 ■ Buriel 2 □ Cremetion 3 □ Removei from Stata Department of important: If any injury or once. 1-23-99 4 □ Donetion 5 □ Other (Specify) All Saints Episcopal Cemetery Avenue, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Fecility Brinsfield Funeral Home, P.A. Thompson Zr. Conald L. M01154 22955 Hollywood Road, Leonardtown, MD 20650 23e. Pert1. Enter the disease, or complication that causad the death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heef failura. List only one make on each line. **Physician** Immediata Cause (Finel disease or condition resulting in daath) /Medical nien Examiner Dua to (or es e consequance of): Examiner SICK ndrow The law requires that the death certificate be executed buriel-transit Sequentielly list conditions, if eny, laading to immediata cause. Enter Underlying Cause (Diseesa or Injury that initioled events resulting in deeth) Lest Dua to (or es e consequence of): and advanced Box 68760. ettending physician Physician/Medical signed by the et Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco uss contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24e. Wes an autopsy 24b. Wera eutopsy findings peen aveileble prior to completion of cause of daeth? performed? this certificate 1 ☐ Yas 2 XNo 1 □ Yas 2 □ No l or Attanding Physician: efter death. Director: After this certifica funeral director, 25. Was case referred to medical exeminer? Be 26. Placa of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Daeth 28e. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be datermined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital c within 24 hours of To the Funeral D completely filled i 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) edical 29a Certifier end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) D 47066 1-22-99 0 30. Neme and eddress of person who completed causa of death (Item 23e) (Type, Print)

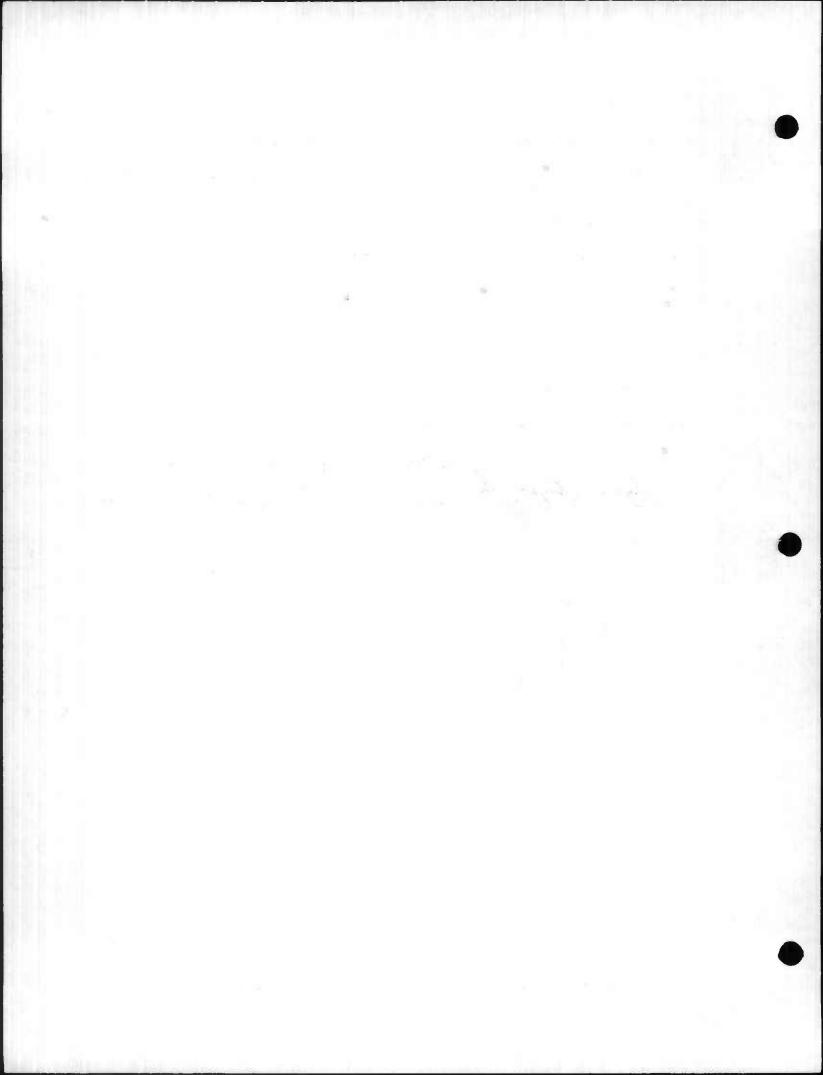
Leonardtown, Maryland 20650

State Registrar Avani D. Shah, M.D.

JAN 22 1999

32, Registrer's Signetura

31. Date filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2355 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Baltimore Medical Sal timore BALTIMORE Center If Under 1 Yeer | If Under 24 Hrs. 6. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Months 1 MM 2□ F 48 200-40-2626 Yrs HANOVER, PA JUNE 13, 1950 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 X Yes 2 □ No WESTMINSTER CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever In U.S. Amed Forces? 540 USA 21158 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 AYes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) POOL BUILDER CONSTRUCTION 17. Father's Name (First, Middle, Last) 16. Mother's Name (First, Middle, Meiden Sumeme) MYRTLE L. MARTIN 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2(158 540 PINEHURST CIRCLE, APT. T4. WESTMINSTER MD
ce of Disposition (Name of Date 20c. Location - City or Town, State ELAINE M. DELL -WIFE 20b. Place of Disposition (Name of cometery, crematory or other place)

GARRISON FOREST
VETERANS CEMETERY 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 1-26-99 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses WETZEL FUNERAL HOME, INC. ideations that caused the drath. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 17331 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seps hours Due to (or as a consequence of): neumonia Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Myeloma ple Due to (or as e consequenca of Part It. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1⊠inpatient 2□ER/Outpatient 3□ DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plecs of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie

Division of Vital Records, P.O. Box 68760,

attending physician and for use es the bunal-transit 98 signed by the a d be detached for paga 2 certificate or Attanding Physician: After this funeral death. ofter death Director: filled in by Hospital

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

7 la marked other than "natural", or itema 23a or traumatic avant, the Madical Examiner must be re

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Certification:

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permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Heelth and Mental Hygiene.
Important: if item 27 Is marked other than "---any injury or other traument-

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24 hours To the Hosp within 24 hor To the Fune completely fi Medical State

(Check only one) 29b. Signature and title of certifie

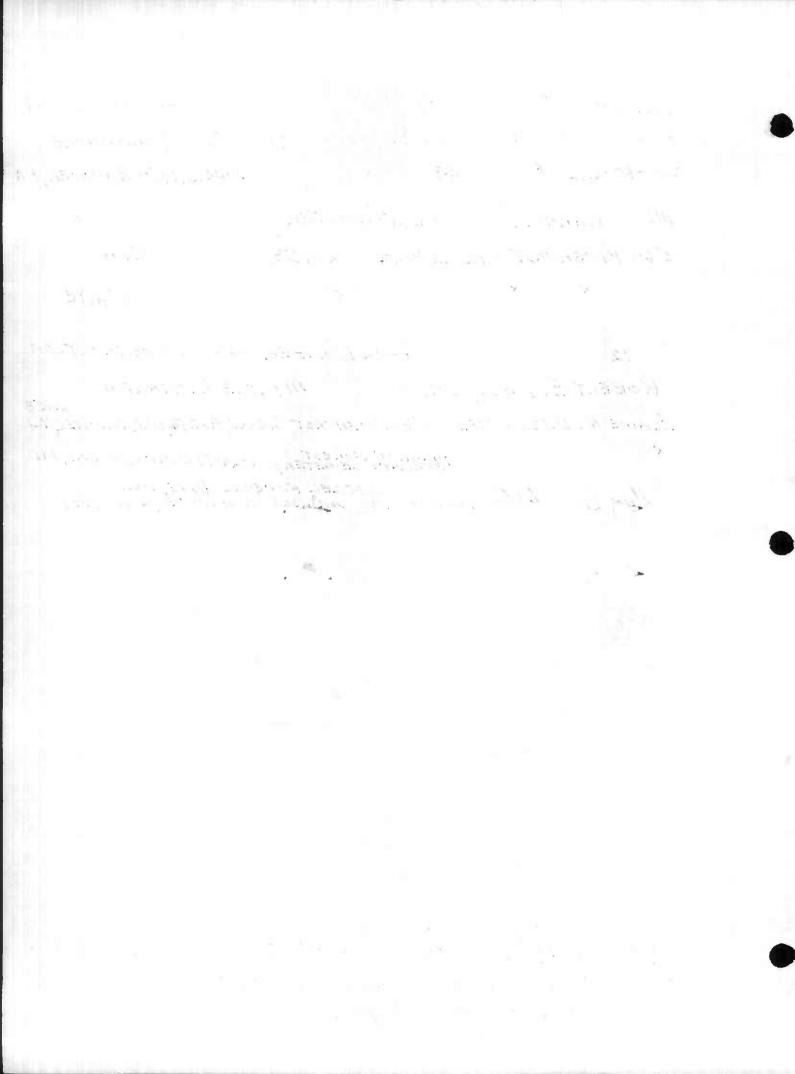
t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

30, Name and address of person who completed cause of death (Item 23e) (Type, Print)

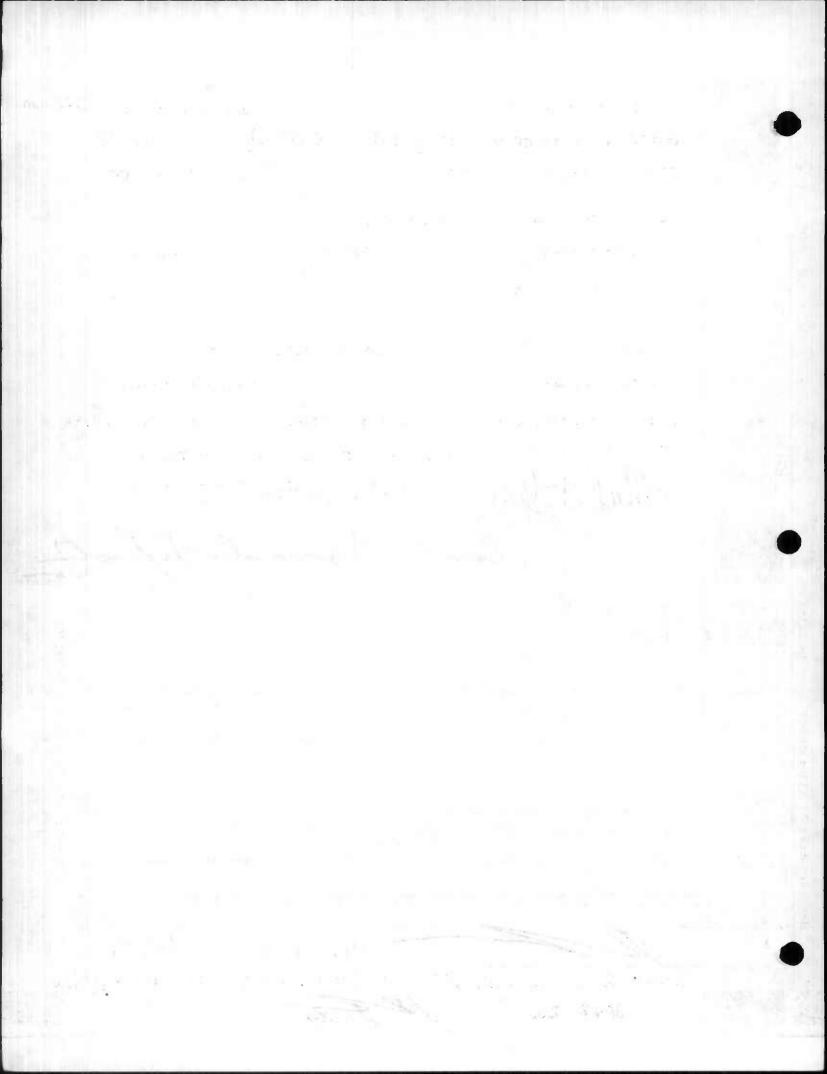
Bounds Baltimore VAMedical Center; 10N. Greene St; Baltimore, MD 21201 hristian 32. Registrer Signature 31. Date filed (Month, Day, Year)

Registrar



State of Maryland / Department of Health and Mental Hygiene

		1 Dagadania Nama /First Middle I	noti		Certi	ficate of	Death		Reg. No.		
Physici	lan	Decedent's Name (First, Middle, Last) JOHN CALVIN GRIMES						2. Dete of Dee Month	Day	Yeer	3. Time of Death 5:22 a.m
/Media		4e. Facility Name (If not institution, g					4b. City, Town, or L	Janua ocation of Deeth	4c. County	999	J. 22 4.1.
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72 hours	Be Completed	15. Decedent's (Specify only highest g	186	. Deceden	t's Usuel Occup	pation during most of work	ina	16b. Kind of B	usiness/Ind	dustry	
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o d is b y	To Be	William Grime	•					McGinn			
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80=2		20a. Method of Disposition 1 XBurlal 2 Cremetlon 3 4 Donetlon 5 Other (Spec	ify)	cemete	ry, cremete	on (Neme of ony or other plea and Cer	metery 1		20c. Location -	•	
permit. Pa Depertmen Important: any injury once.		21. Signature di Flunerei Service Lic	WALL STREET		22. N	ame end Addre	wright land ave	Funer	al Hom	ne	
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ysician: The	Be	25. Wes case referred to medical exeminer?					26. Plece of Deet	h (Check only or	ne)	-	
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i or Attending Phi after death. Director: After thi d in by the funeral	Certification:	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not	20				Yes 2 □ No	28d. Describe h			
To the Hospital or Atlanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 ☐ Homlcide determined	building, etc	c. (Specify)				28f. Location (S City or Tow	n, Stete)		
Hoa 124 h Fun letely	edicai	(Check only one)	hysician: To the best of miner: On the besis of and menner ste	exemination en	d/or Invest	igetion, in my o	pinion, deeth occurr	end due to the c ed et the time, d	ete end plece,	and due to	the cause(s)
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ntVA		30. Neme and eddress of person who	completed cause of d		(Type, Prin	(1)	12656 te Ave	, Th.	-CO ()	John L	\\\/ ·



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Elizabeth Marie Gregory Day GREGORY ELIZabeth M 19 1999 JANUARY 11:45 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death H Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sept. 27, 1916 Pennsylvania MARYS Hospital 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 1 □ M 2 K F Months Yrs. 050-20-7733 82 Usuai Residenca of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1□ Yes ŽŽNo Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7382 Woodhaven Drive 20646 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indian. Biack, Whita, afc. 1 ☐ Naver Married 2 ☐ Marriad 1 Yas 2 XNo Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grade completed) 16a. Decadent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Account Manager Telecommunications 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Franklin Miller Elizabeth Jane Livingston 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Richard P. Gregory - Son 7382 Woodhaven Drive, La Plata, MD 20646 20a. Method of Disposition 20b. Piaca of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State f ☑ Burial 2 ☐ Cremation 3 ☐ Ramovei from Stata 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 1-25-99 Waldorf, MD 22. Name and Address of Facility Huntt Funeral Home, Inc. 21. Signature of Funeral Service Licenses John P. Knisley MO1164 P. O. Box 156, Waldorf, MD 20604-0156 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarvai Batweer Onsal and Death tmmediate Cause (Final disaasa or condition resulting in death) Kaspirato Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpafient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 5 Pending 1 Yes 2 No

Physician /Medical Examiner

Physician

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Moul cal Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Mad. all Examina

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Division of Vital Records, P.O.

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To the To the To the

29e. Certifier

(Check only one)

27. Menner of Death 1 Natural

2 Accident 3 Suicida 4 T Homicide

investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and menner as stated.

CRONARDTOWN, MD 20650

29b. Signatura and fitta of cartifiar (i. Wasler

29c. Licansa number D3960S

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year)

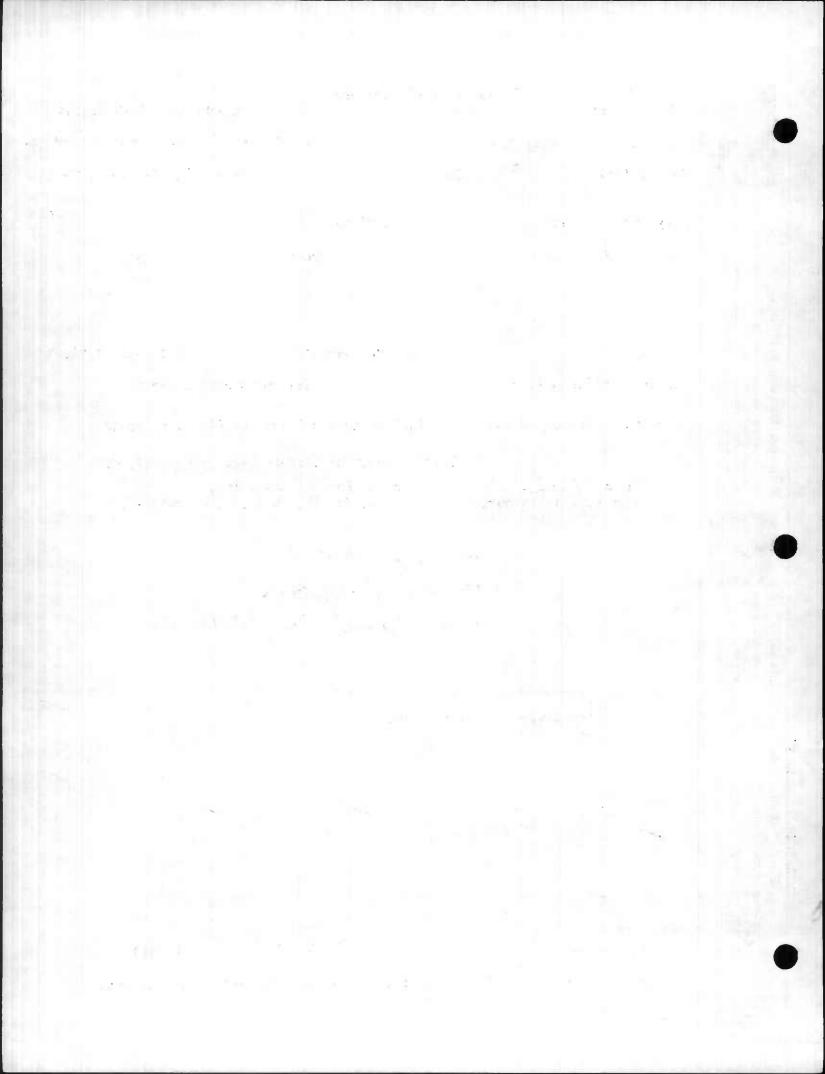
30. Name and address of person who completed cause of death (item 23a) (Typa, Print)

1999

C. WESLEY PAGE mD 31. Data filed (Month, Day, Year) JAN 22

ST. MARYS HOSPITAL 32. Registrar's Signafura

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month RUTH MARGARET HERWIG 5:45 pm Jan 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth center | Hunder 1 Year If Under 24 Hrs. 8. Data of Birth Hours Min. APR. 8, 1923 Charlestown Care Baltimone 5. Social Sacurity Number 7. Age (In yrs. lest birthday) Birthplace (Stata or Foreign Country) 1□ M 2X F Months Deys 75 217-14-2685 MASSACHUSETTS Usual Rasidance of Dacadant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 ☐ Yas 2 No MARYLAND BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 709 MAIDEN CHOICE LANE 21228 U.S.A. 12. Was Dacedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Bleck, Whita, atc. 1 Navar Merried 2 Marriad Specify: WHITE 1 ☐ Yas 2 ☑ No Specify: 3 X Widowed 4 □ Divorced Yeer or Datas: 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grade complated) 16b. Kind of Business/Industri ANNE ARUNDEL CO. College (1-4or 5+) Elamantary/Secondery (0-12) BOARD OF EDUCATION 12 SECRETARY 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maiden Sumama) WILLIAM CROSS ELSIE YATES 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) SCOTT L. HERWIG , SON 20 GRAY DRIVE, PASADENA, MARYLAND 21122 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 XBuriai 2 ☐ Cramation 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Othar (Spacify) GLEN HAVEN MEMORIAL PARK 1/23/99 GLEN BURNIE, MARYLAND 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W., GLÉN BURNIE, MARYLAND 21061 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata intervel Betwaen Onset and Death Immedieta Causa (Final diseasa or condition rasulting in daath) Cerebro Vascular Accident days Due to (or as a consaquanca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dua to (or as a consequance of):

Physician /Medical Examiner

law requires that the death certificate be axecuted

Tha

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within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

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Division of Vital Records, P.O. Box 68760,

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Hem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examiner must be notified as

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If Hem 27 is marked other than "natural", or item any injury or other traumatic event, the market and once.

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that initiated events rasulting in death) Last	Dua to (or as a consequance of	of):				
Part II. Other significant conditions Drabetes	contributing to death but not ra	suiting in the undarlyin	g cause given in Part i.	23b. Did tobacco use co	ontribute to the cause of death?		
				24a. Wes en autopsy performed?	24b. Wara autopsy findings aveilable prior to complation of ceusa of death?		
25. Was casa referred to medical			26. Place of De	eeth (Check only ona)			
examinar? 1 ☐ Yas 2 Ø No	Hospital:	☐ ER/Outpatient 3☐	DOA Other: 41 Nursing	Home 5 ☐ Residence 6 ☐ Ott	nar (Specify)		
27. Menner of Death 11 Natural 5 ☐ Panding 2 ☐ Accident Invastigation		28b. Time of Injury	28c. injury et Work? 1 Yas 2 No	28d. Dascribe how injury occur	rred		
3 Sulcide 6 Could not l		noma, farm, straat, factify)	28f. Location (Street and Numi City or Town, State)	 Location (Street and Number or Rural Routa Number, City or Town, Stata) 			
29a. Cartifiar 1	hysician: To the best of my kn- miner: On the basis of examin- and menner steted.	owledga, daath occurre etion and/or investigeti	ed et the tima, data and piec on, in my opinion, daath occ	e, end dua to the causa(s) and mourred et the time, dete and placa,	ennar as stated. and due to the cause(s)		

MI)

30. Name and address of person who completed causa of death (itam 23a) (Type, Print)

Salazar

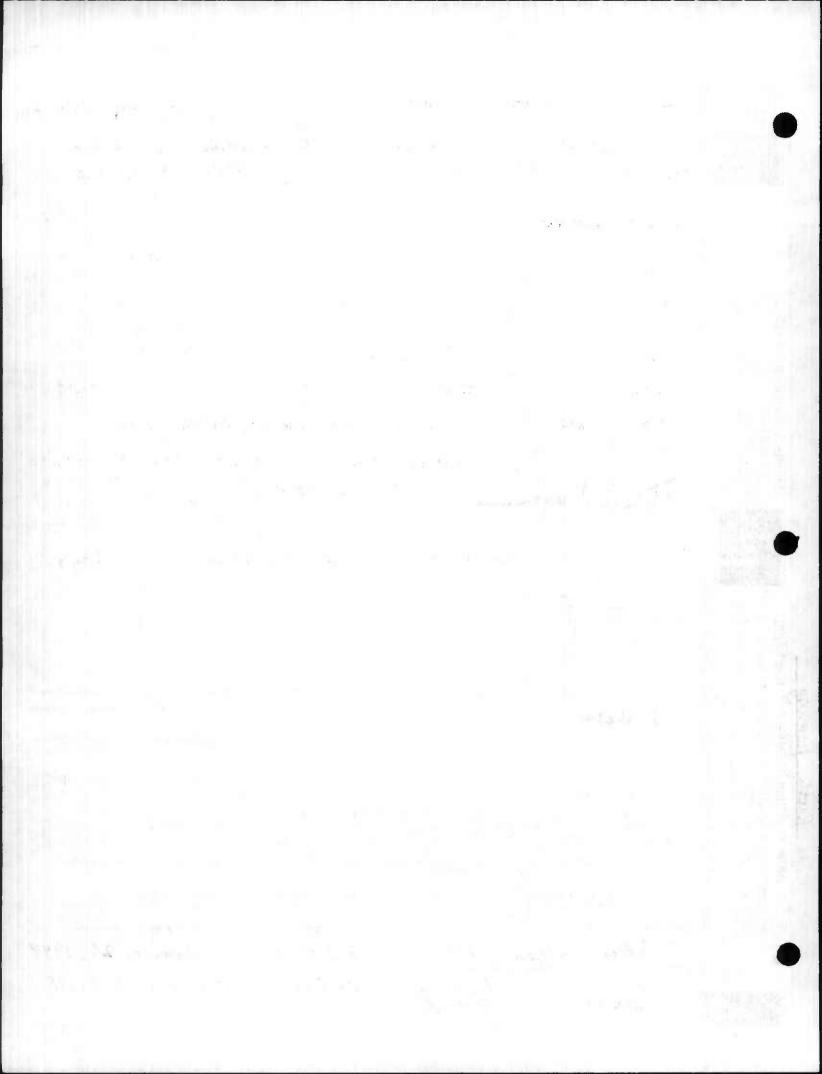
29c. License number

7// Maidenchoice Lane, Catonsville, MD, 21228

29d. Date signed (Month, Day, Year)

January 20, 1999

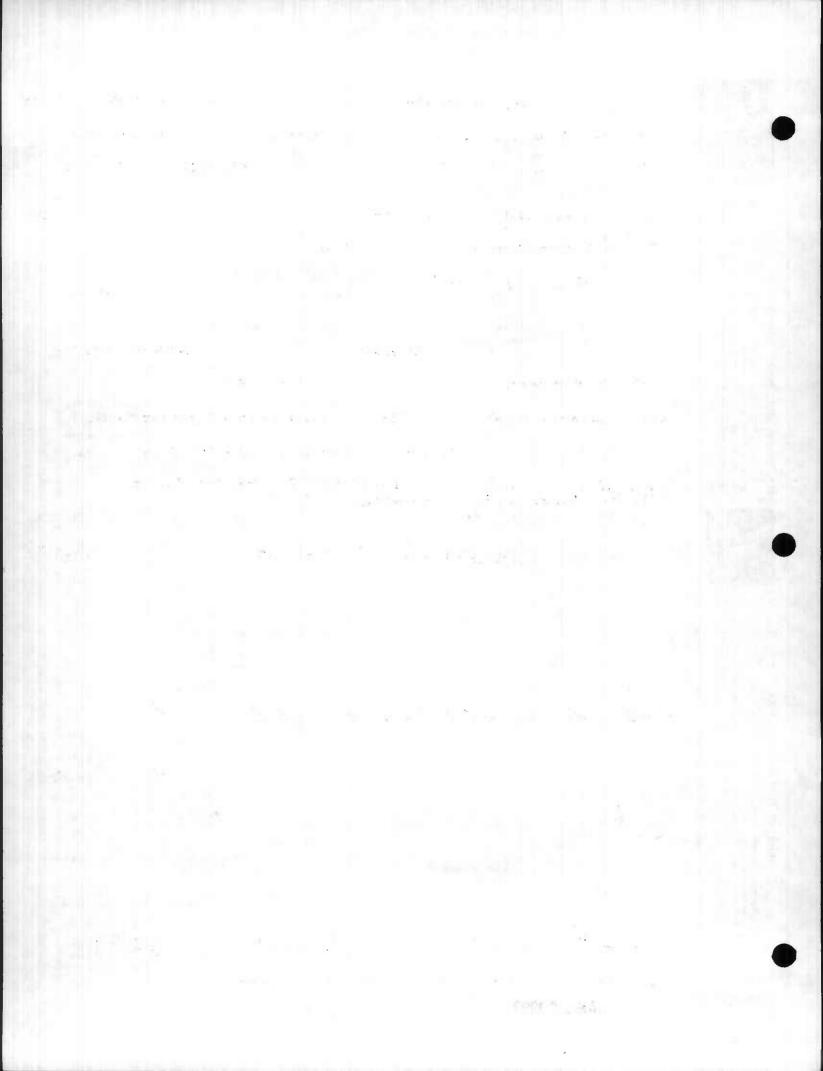
State Registrar



State of Maryland / Department of Health and Mental Hygiene 9

					Ceruni	cale of	Dealli		1	Reg. No.			
	ysician Medical	Charles Joseph Houseworth								Death 3. Time of Death uary Day 14 1999 8:00AM			
	aminer	4a Facility Name (If not institution, g 3543 South Ri					4b. City, Tow Edgewa		cation of Death		of Death Aru		
Fund Direct		060 14 1222	Sax 1 M 2 □ F	Age (In yrs. lest bin		Inder 1 Yaar oths Days		Min.	8. Data of Birt 05/14/2	Year)	9. Birth New	placa (Stete or Foreig Pork	
Meryland	fed at	Usual Residence of Dacedent 10a. Stata 10b. County MD Anne A		own or Location ewater							10d. Inside City Limits		
with the	iner must be notified Funeral Director	10e. Street and Number 3543 South Riv	2	10	f. Zip Coda 21037	7			10g. Citizen of USA	What Cou	ntry?		
21215-0020 Within 72 hours after death with the Meryland jiene. than "natural", or items 23a or 28s-1 show	Examiner mu by Funera	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	nt Ever in U,S. 6? WWII] No		Decedant of I specify Cub as 2 X No		in? (Spe Puarto	ocify Yas or No Rican, etc.)	14. Rad Bla Specif	can indian, , etc. hite			
within one.	r, the Medical I	15. Decedent's I (Specity only highest g Elementary/Secondary (0-12)		r 5+)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Salesman			during most of working			usiness/ir	dustry	
Maryland 2 12 should be filed n and Mental Hygie	To Be C	17. Father's Neme (First, Middle, Les Charles W. Hous							(First, Middle, Burt	Maiden Sumar	ne)		
C TO N	other treums	19a. Informent's Name/Relationship Nancy Housewort		3	3543 S	outh I			ace/Edg	er, City or Town gewater	MD 2	1037	
Peges nent of int: If it		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		e Metrop	ny, cremetor Dolita	n Cren	natory		/16/98	Alexar	dria		
Baltim pemit. Peg Department Important: I	eny in	21. Signature of Funeral Service Lice	m Was	Dh.			ess of Facility neral of MD 21		emation	ion Services			
Physic /Medi Exami	ical ner	Immediate Cause (Final disease or condition resulting in death)	. ALZ	HEIMER Due to (or es a	consequence		KENT	A			-	Onsat and Death	
Certificate be executed ding physician and	letached for use as the buriel-transit Physician/Medical Examiner												
U	o	Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of										to the cause of death	
S, P.C.	b b	ATHEROSCLEROTIC CEREBRONAS CUZAR DISEASE 10 YOU 2000 3								1	obably 4 Unknow		
aw requi	2 should				24a. Wes	an autopsy rmed?	8	Vere autopsy findings vallable prior to ompletion of causa f death?					
VITAL HICIAN: The Iclan: The Certificate h	Be Com	25. Was case referred to medical	T				26. Place	of Death	1 Check only o		1	Yes 2	
On Of VITa ding Physician: th. After this certific	E P	examiner? 1 Yes 20 No 27. Manner of Death 1 Natural 5 Pending investigati	Hospitel: 1 ☐ Inpa 28a. Dete of In (Month, E	jury 28b. 1	itpatient 3 Time of njury	28c. Inju				dence 6 GOtt how injury occu	Other (Specify)		
= = 0	led in by the funera Certification:	2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 28a. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)						28f. Location (Street end Number or Rurel Route Number, City or Town, Stele)					
To the Hospital or / within 24 hours after To the Funeral Dire	edical (29a. Certifler 1 Certifying P (Check only one) 2 Medical Exa	hyeiclan: To the bes miner: On the basis and manner:	of examination an	dor investig	irred at the tration, in my	ime, date and opinion, deat	d placa, a	and due to the ed at the time,	ceuse(s) end m date end place,	enner as and due	stated. to the cause(s)	
To the within 2 To the	Me	29b. Signalure at this of armiti-	azelli)		29c. Lican	se number	4		29d. Date signe	S (Nonth	, Dey, Year)	
		30. Name and address of person who Peter Graze, M		death (Item 23e) estgate I			is MD	2140	1				
Red	State	31. Date filed (Month, Day, Year) JAN 2 0	32. Regis	ar's Signature	B.	do							

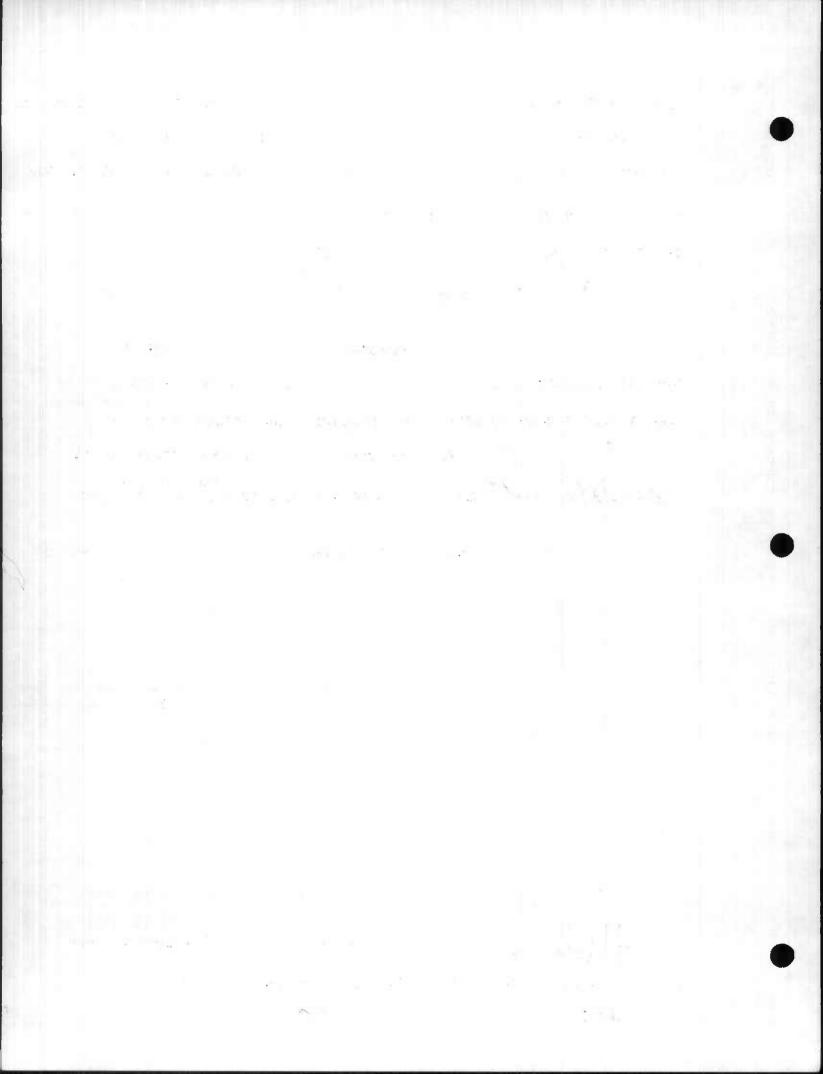
Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth **Physician** RALPH JASPER HIGHT JANUARY 17, 1999 1:00 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 911 BROADFORD ROAD GARRETT If Under 1 Yaar | If Under 24 Hrs. Birthplece (Steta or Foreign Country) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) 8. Dele of Birth (Month, Dey, Year) **Funeral** Days Hours 1**X**0 M 2□ F Yrs. AUG 27, 1927 235-38-6118 WEST VIRGINIA **Director** Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yas 2 No GARRETT Director OAKLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 911 BROADFORD ROAD 21550 USA Funeral daath 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: CAREER Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiane. Important: If flem 27 is merked other than "natural; or the any injury or other traumatic event, the Mentel Exercise. 1 Never Married 2 N Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 SALESMAN MACHINE 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be BENJAMIN FRANKLIN HIGHT LETTIE OLIVE HEAVENER 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) JARLATH FITZWATER-HIGHT/ WIFE 911 BROADFORD ROAD OAKLAND, MD 21550 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State OMEGA CREMATORY 1/18/99 MORGANTOWN, WV 4 ☐ Donation 5 ☐ Other (Specify) re of Preseral Ser 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused tha daath. Do not entar tha mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final 6 MONTHS CREUTZFELDT - JACOB disaase or condition resulting in deeth) Examiner Due to (or as e consequance of): Examiner physician and s the burial-transit Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or as a consequence of) certificata be execu P.O. Box 68760 **Physician/Medical** Due to (or as a consequence of) 98 attanding | ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in tha underlying cause given in Pert I. s been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings avellable prior to completion of ceuse of deeth? 24a. Was en eutopsy Completed performed' page 2 hes 1□ Yes 2 No 1 □ Yes 2 □ No certificate Division of Vital or Attending Physician: aftar death. Director: After this certific funeral director, 25. Wes case referred to medicel examiner?
1 ☐ Yes 2 ☒ No Be 26. Piece of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 8 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 XNaturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner stated. To the Hospi within 24 hou To the Funer completaly fil Medical 29e. Certifier 29b. Signatura and tile of certific 29c. License number 29d. Date signed (Month, Day, Year) D15333 JANUARY 18, 1998 10 ung 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 114 VA THOMAS G. JOHNSON, M.D. 311 N. FOURTH ST. OAKLAND, MD 21550 32. Registrar's Signeture 31. Date filed (Month, Dey, Yeer) JAN 1 9 1999 Registrar



		State of Marylar		ificate of			Reg. No.	U	2191	
Physician /Medical	1. Decedent's Name (First, Middle, La Helen Alice	2. Date of Dea Month Januar		3. Time of Death 1999 12:15 PM						
Examiner	4a Fecility Neme (If not institution, gir				4b. City, Town, o	r Location of Deeth			1 -	
F	St. Mary's Nurs			Mary						
Funeral Director		Sex 1 □ M 2 □ F 7. Age (In yrs. 88	1111	Months Days	Hours Mi	s. 8. Date of Birt (Month, Da August 3]	, 1910	Maryla	lace (State or Foreign ind	
pu ≱	Usual Residence of Decedent 10e. Stete 10b. County	10c. Ci	ty, Town or Loca	ation				10	0d. Inside City Limits	
Manyla F sho	Maryland St. Mar		Bushwood						1 ☐ Yes ② CXNo	
or 28a	10e. Street and Number			10f. Zip Code			10g. Citizen of		iry?	
ath w	Joyce D							A . e - America	en Indian	
The roots are cean with the maryand featurel, or tems 23s or 28s-f show soiral Examiner must be notified at leted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever In U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	lf.	as Decedent of I Yes, specify Cub	oan, Mexican, Pue	(Speciny Yes or No erto Ricen, etc.)		ck, White, e		
than "nature than "nature the Medical	15. Decedent's E (Specify only highest gr.	ducation ade completed)	ent's Usual Occu ind of work done	pation during most of weed)	rorking	16b. Kind of B	usiness/Ind	lustry		
	Elementary/Secondery (0-12)	College (1-4or 5+)		ONOT use retire	(a)		II C	Gove	rnment	
Mental Hygiane. arked other than etic event, tre M To Be Comp	17. Father's Name (First, Middle, Last)	beaci	LSCION	18. Mother's N	ame (First, Middle,			Timent	
marked matic ev	John Norman Siou	ssa			Alice	e Henriet	ta O'Br	ien		
ls m	19a. Informant's Name/Relationship Gail Osborn/Daugh	ter	26 78 2	2 Yowais	ki Mill	Rural Route Number Rd., Mec	hanicsv	ille,	MD 20659	
in the	20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci	Themoval from State	arles Mem	ition (Neme of etory or other pla orial Gard	dens	1/30/99	Leonardto	own, Ma	aryland	
Department important: any injury once.	21. Signature of Funeral Service Line 23a. Pert1. Enter the disease, or con shock or heart failure. List only Immediate Cause (Final disease or condition	Baroline.	P. th. Do not enter	.O. Box	270, Led		, Maryl			
attending physician and if for use as the buriel-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last	b. Recurre Due to (c	or as a consequ	dence of):	of .	n Peclio Faulu	ns e	3	, muts. as years	
igned by the attending to be detached for use e	Part II. Other algnificant conditions	contributing to death but not res	sulting in the und	derlying cause gi	iven In Part I.		lobacco use co Yes 2 No		the cause of death?	
s been signed 2 should be d						24a. Was	an autopsy med?	ava cor of c	ere autopsy findings allable prior to mpletion of cause death?	
this certificate has be ral director, page 2 s	25. Was case referred to medical examiner?				28. Place of D	Peath (Check only o				
this ce al dire	1 ☐ Yes 2 No		ER/Outpatient	3LI DOA	ther: 4 Nursing Home 5 Reside				1)	
or death. octor: After by the funer iffication:	27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investigation		28b. Time of Injury	M 28c. fnju Wo	ork? ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red		
rs after death. at Director: After to the in by the funeral Certification:	3 ☐ Sulcide 6 ☐ Could not to determined		ome, farm, stre	et, factory, office		28f. Location (City or Tou	Street and Numi vn, Stete)	ber or Rura	l Route Number,	
in 24 hours he Funer pletely fil edical		nysician: To the best of my kno miner: On the basis of examina end menner stated.								
To the com	29b. Signature and title of certifier	4			15e number 147066			e signed (Month, Dey, Year) - 28 - 99		
m	30. Neme end eddress of person who A. D. Shah, MD	completed cause of death (Ite			, Maryla	ind				

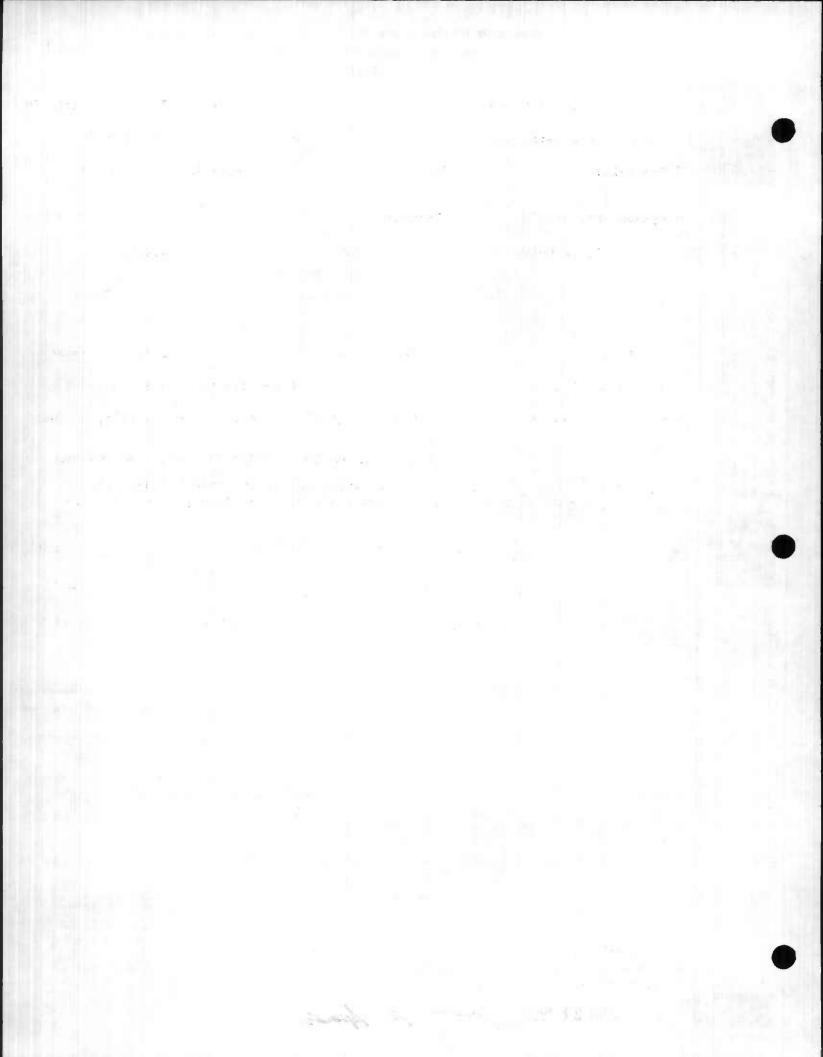
DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 8 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Deeth 26, 1999 11:30 AM George Parran Johnson Jr. January 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth 39999 Big Chestnut Road Clements St. Mary's 6. Sex 1 M 2 □ F if Under 1 Yeer If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months Days Hours Yrs. 81 August 17, 1917 Maryland Usuel Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No St. Mary's Clements 10f. Zip Coda 10g. Citizen of What Country? 39999 Big Chestnut Road 20624 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Rece - Amarican Indian, Black, White, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Farm Farmer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) George Parran Johnson Sr. Charlotte Anne Tennyson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Name of cametery, cremetory or other place)

20b. Place of Disposition (Name of cametery, cremetory or other place)

20c. Location - City or Town, Sta Catherine Johnson Wible/Niece 20c. Location - City or Town, Stata 1 XXBuriai 2 ☐ Cremetion 3 ☐ Removel from Stete Charles Memorial Gardens 1/30/99 Leonardtown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650

23e. Pert / Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onsat and Death Suicide 65W TO HEAD. Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown (depression 24b. Were autopsy findings evelleble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 No

Physician /Medical Examiner

permit. Page Department of Important: If any injury or

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or itema 23a or 28a-f show the Medical Evanings must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Hauth and Mental tyglene.
ant: if item 27 is marked other than "natural", or item its over the transment over the item.

altimore, Maryland 21215-0020

deeth with the Meryland

5. Social Security Number

217-36-6040

Maryland

10e. Street end Number

8th

20e. Method of Disposition

Immediate Ceuse (Finel

disease or condition resulting in deeth)

10e. State

Directo

Funeral

by

Completed

Be

Examiner physician and s the burial-transit Physician/Medical ding p use signed by the el þ Completed Be Certification: To

The law requires that the death certificate be executed

Hospital

To the Hosp within 24 hor To the Fune completely fi

8

Division of Vital Records, P.O. Box 68760,

After this certificata hes funeral director, page 2 after death.

Director: After this certifica filled in by 24 hours

25. Wes

29b. Signature and title of certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Wes cese referre	ed to medical				26	. Place of De	eeth (Check only one)
examiner? Yes 2□ N	ło	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpetient	3□	DOA Other:	4 Nursing	Home 5 Residence 6 □Other (Specity)
27. Manner of Death 1 □ Naturel 2 □ Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury et Work? 1 ☐ Yes	2 No	28d. Describe how Injury occurred
3€ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h	ome, farm, stree	t, fact	ory, office		28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner steted.

29d. Date signed (Month, Dey, Year) 29c. License number

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

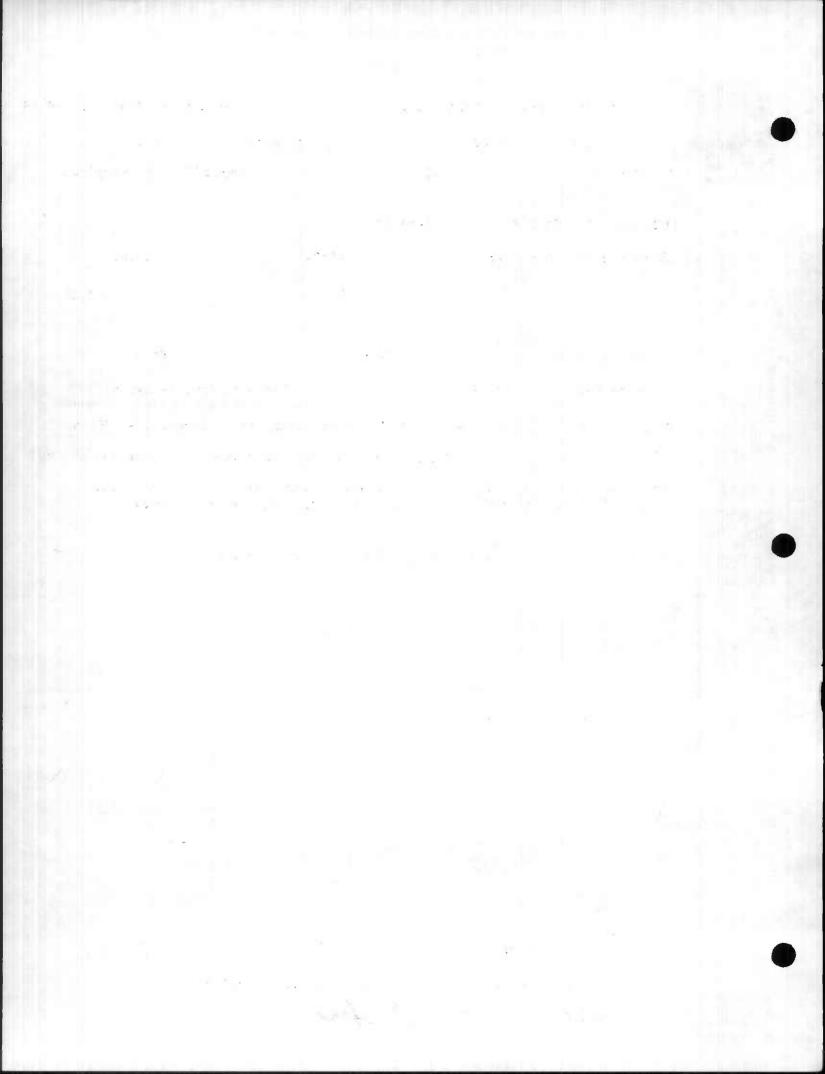
William Boyd II, MD Leonardtown, MD 20650

Registrar

Medical

31. Dete tiled (Month, Day, Year) JAN 2 8 1999

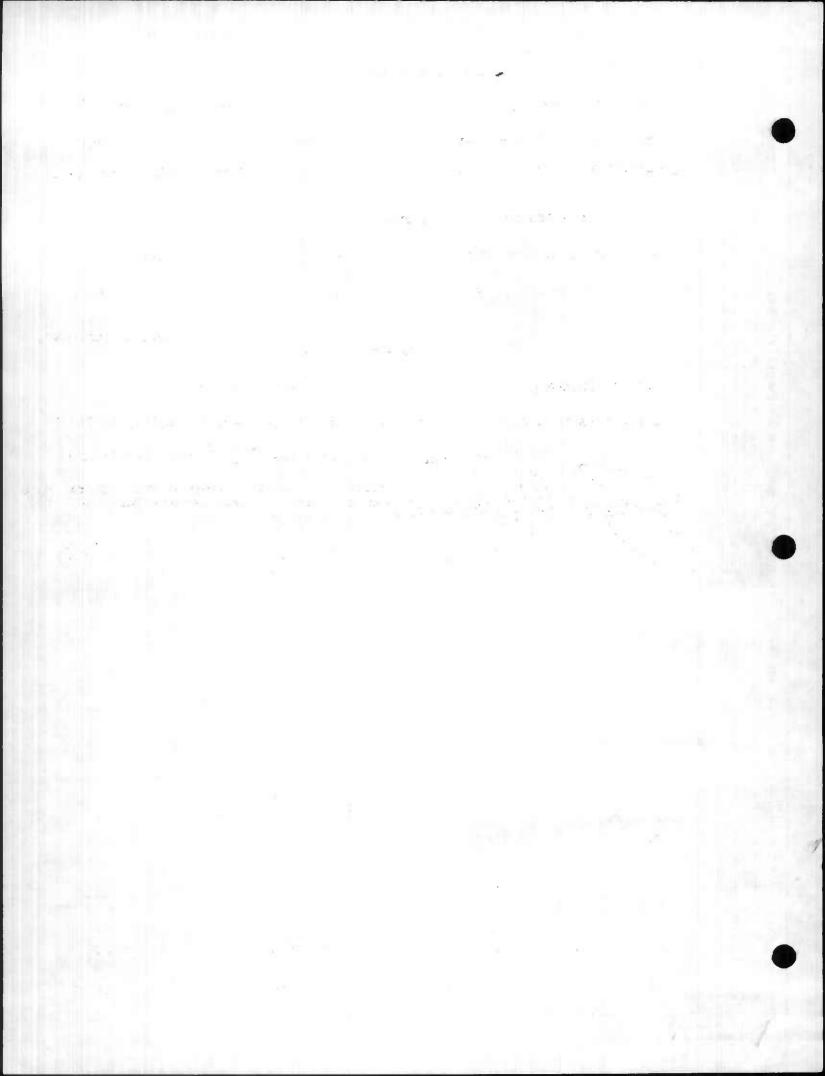
32. Registrer's Signeture Chippine and



State of Maryland / Department of Health and Mental Hygiene Amend. 4a,10e 1/22/99 SM AACO Health Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** 1:45 am James J. Kavanaugh 20, 1999 January * /Medical 4a Facility Nama (Inamediation, give street and number) 4b. City, Town, or Location of Death Examiner 1419 Came St. Claire Road Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) June 7, 19 Birthplece (Steta or Foreign Country) **Funeral** Deys 1MM 2□ F Months Hours 220-56-0605 48 Maryland Director Usual Residence of Deceden the Maryland 10a Stete 10c. City, Town or Location 10d. Inside City Limits 10h County ns 23a or 28a-f show MD Anne Arundel 1 ☐ Yes 2 No Director **Annapolis** 10e. Street end Number DE 10f. Zip Code 10g. Citizen of Whet Country? with 1419 Cape St. Claire Road 21401 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No if Yes, Give Yeer or Detes: r than "natural", or items Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 Naver Married 2 Married White altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowad 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Capital Compressor Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. General Manager . Pages 1 and 2 should be filed w tment of Health and Mental Hygler tant: If Item 27 is marked other th lury or other traumatic event, the 12 18. Mother's Neme (First, Middle, Maidan Sumeme) 17 Fether's Neme (First Middle Last) Be James T. Kavanaugh Thaden Jane 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Darlene Kavanaugh/wife 1419 Cape St. Claire Road, Annapolis, MD 21401 20b. Piece of Disposition (Neme of cematery, cremetory or other piece) 20e. Method of Disposition Jan 23 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If Glen Haven Memorial park Glen Burnie, MD 4 ☐ Donetion 5 ☐ Other (Specify) 1999 21. Signature of Funeral Service Lice 22. Name and Address of Fedito Barranco & Sons, P.A. Severna Park Funeral Home C495 Gov. Ritchie Hwy., Severna Park, MD 21146 ter the mode of dying, such as cardiac or respiratory arrest, Physician Lyears arcinoma Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical Cause (Disease or Inju that initiated events resulting in death) Last 8 Due to (or as a consequence of): 88 985 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown ligned by þ 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 見 page 2 1 Yes 2 No 1 □ Yes 2 □ No contificate Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5. Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA # 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After Nutural if or Attending after death. 1 Yes 2 No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled Hospital Lacertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 295. Signature end title of pertifier 29c. Licensa number 29d. Data signed (Month. Day, Year) 1-20-89 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Ridgely tre Annapolis 21401 Peterson Robert 31. Dete filed (Month, Day, Year) JAN 2 2 1999 32. Registrer's Signeture State Lever Registrar



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Certification: To

edical

11 Yes 2 No this 27. Manner of Death After 1 Netural death. n 24 hours after death.

Ne Funeral Director: A
pletely filled in by the f

2 Accident 3 Suicide 4 Homicide

(Check only one)

29a. Certifier

6 X Could not be determined

5 Pending investigation

28a. Dete of tnjury (Month, Day Year) Found:1-15-99 28e. Plece of trijury - At home, ferm, street, fectory, office building, etc. (Specify)

Hospitet: 1 ☐ Impatient 2 XER/Outpatient 3 ☐ DOA

28b. Time of tnjury Found23

28c. tnjury at Work?

UNKNOWN

1 Yes 2 No

28d. Describe how injury occurred UNKNOWN 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2594 RIVA ROAD, #20A

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

111 Penn Street, Baltimore, Maryland 21201

ANNAPOLIS, MARYLAND 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to tha cause(s) and manner stated.

29b. Signature end title of certifier

Hon

O.C.M.E.

29c. License number

29d. Data signed (Month, Day, Year) January 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Will

31. Date filed (Month, Day, Year) JAN 2 1 1999 32. Pegistrar's Signature

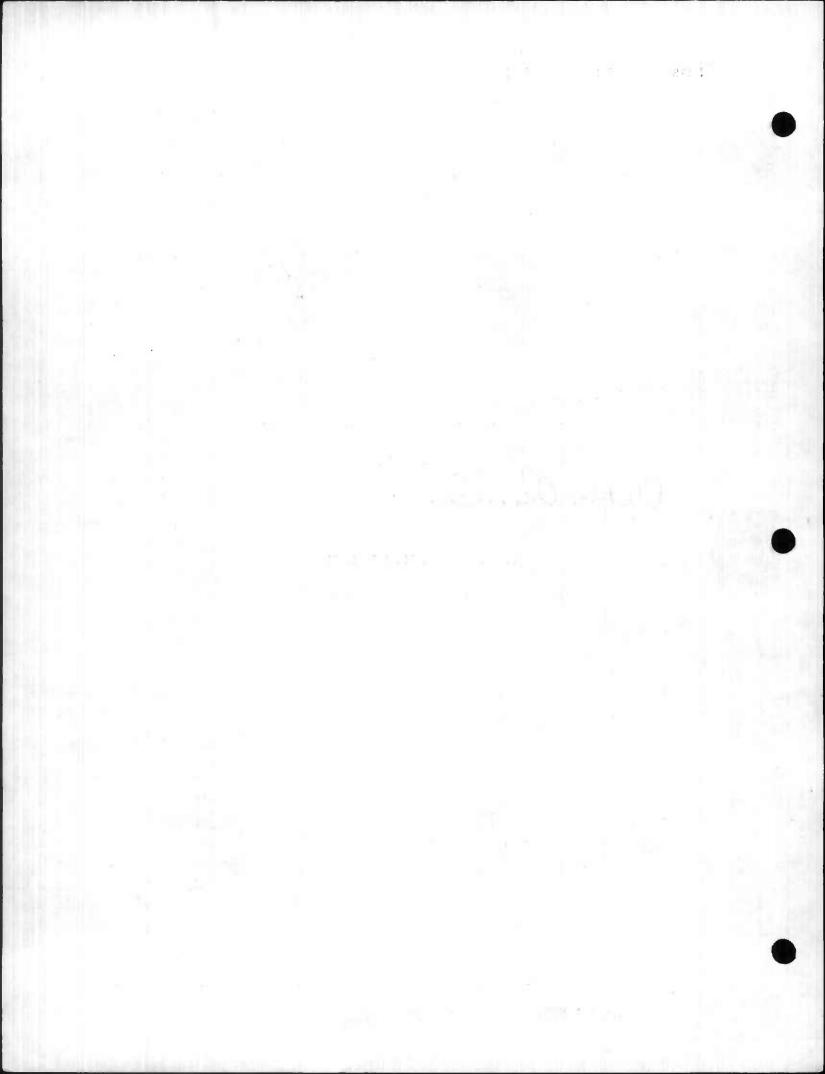
Registrar **DHMH 16 Rev 6/95**

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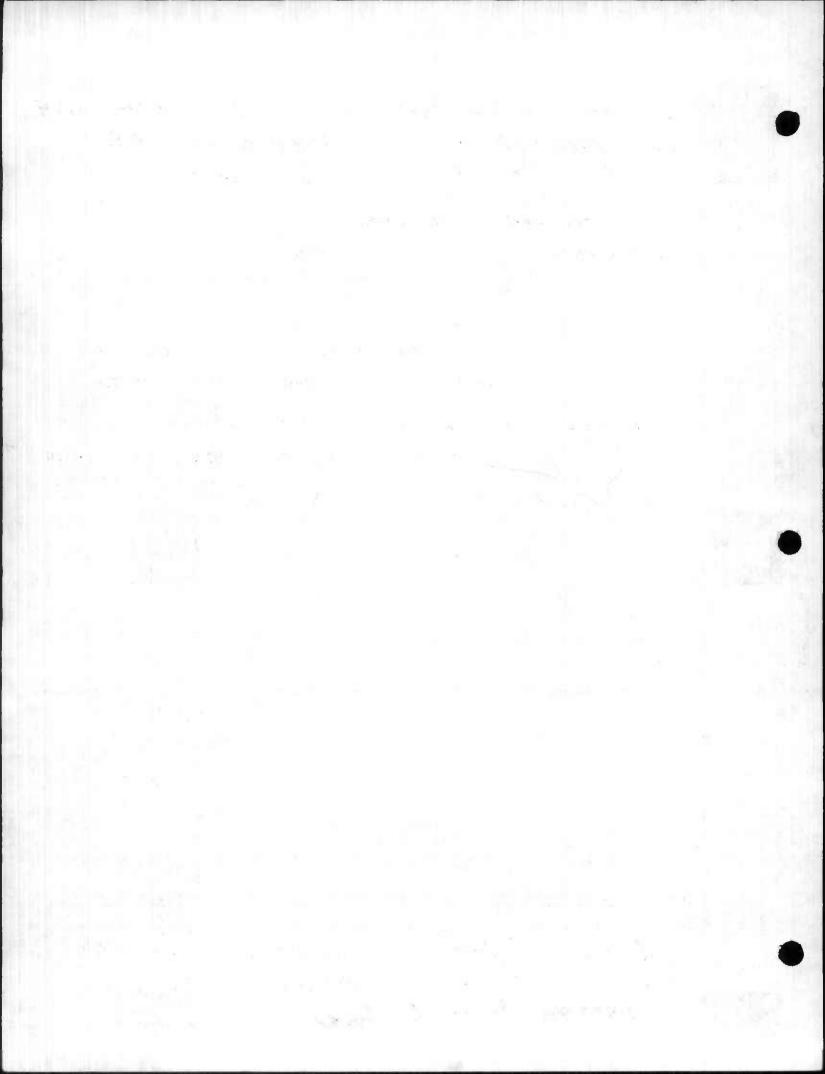
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Hospital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ector	_	214-30-7132	1□M 2QF	70 Yrs	Months	Days Hours	Min. (Month, D 5-08		Country) MI)		
£ == 1	_	Usual Residence of Decedent Oa. State 10b. County	11	0c. City, Town o	or Location				10d. Inside (
notified at		MD Anne	Arundel		Burnie				1 ☐ Yes		
or 28	1	0e. Street and Number			10f. Zij	p Code		10g. Citizen of What			
d le		207 Marie Avenu	e			21060		U.S.	Α.		
natural, or tenns 238 or 288-1 and notal Examiner must be notified at etect by Funeral Director	1	Marital Status Nevar Married 2 Married Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 12 No If Yes, Giva Year or Dates:	orces? If Yes, specify Cuba 2 No iva 1 □ Yes 2 No			? (Specify Yes or N uerto Ricen, atc.)	o- 14. Rad Bla Specifi	ce - Amarican indian, ck, White, etc. WHITE		
9		15. Decedent's I	15. Decedent's Education (Specify only highest grade completed)			ual Occupation		16b. Kind of B	usiness/Industry		
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t a t	1	19a. Informant's Name/Relationship				s (Street and Number of					
other tr	2	SOPHIA BULLOCK Oa. Method of Disposition	-SISTER-IN-L	20b. Place of Di	isposition (Na	AL VINE LAI	NE, FORT I		LORIDA 339 City or Town, State		
5		1 ☐ Buriai 2 ☐ Cramation 3 4 ☐ Donation _ 5 ☐ Other (Speed			VEN ME	o <i>ther piace)</i> MORIAL PARI			RNIE, MARYI		
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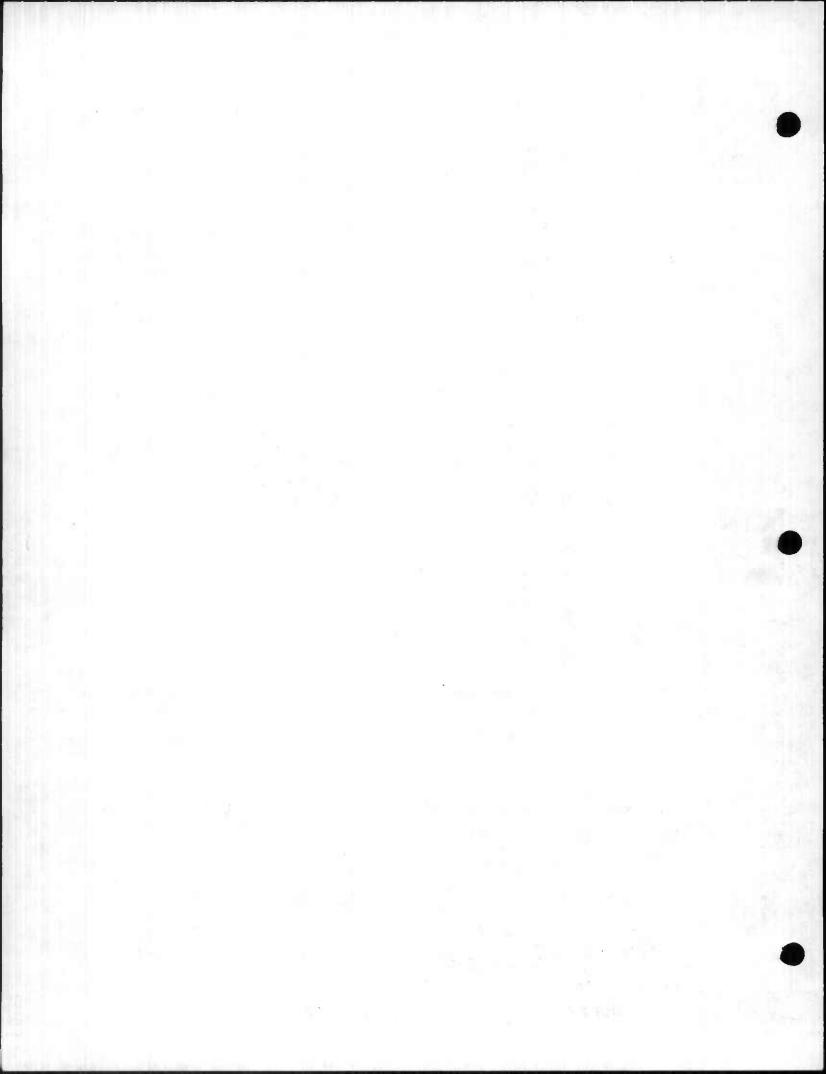
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State of Maryland / Department of Health and Mental Hygiene 99 027

		Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death						•	3	3. Time of Death	
Physicia		Ida M.	KINSINGER					Month January	Day	Year	5:30 AM
/Medic Examin		4a. Facility Name (If not institution,		r)			4b. City, Town, or		4c. County		0:30 AM
LAGIIIII	ÇI	8004 Garrett Hi					Oakla				
Funeral				lge (In yrs.	. last birthday)	If Under 1 Year	If Under 24 Hrs.			9. Birtholaci	e (State or Foreign
Hygiena. then "natural", or itams 23a or 28a-f show and, the Medical Examiner must be notified at		522-48-7000 Usual Residence of Decedent	1□M 2∏F	(66 Yrs.	Months Days	Hours Min.	July 19	Year) , 1932	Iowa	e (State or Foreign
show	ŗ.	10e. State 10b. County		10c. C	ity, Town or Lo	cation					Inside City Limits
23a or 28a-f show	Director		rett		0aklar	nd					1 ☐ Yes 2 ☒ No
0.0	Dir	10e. Street and Number				10f. Zip Code		10	g. Citizen of	What Country	?
23	rai	8004 Garrett Hi					1550		U.	S.A.	
natural, or itsma	by Funeral	11. Marital Status 1 ☐ Never Merried 2 ☒ Merrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No	If	Vas Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (S ean, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	14. Rad Bla Specify		
	P	15. Decedent's		•	16a Deced	ent's Usual Occur	netion	1	6h Kind at B	Whit usiness/Indust	
important: If item 27 is marked other than "natur any injury or other traumatic evant, the Medical once.	Completed	(Specify only highest Elementary/Secondary (0-12) 8th	grade completed) College (1-4or	5+)		kind of work done OO NOT use retire	petion during most of wor d)	king	Hor		шу
's Tr	Bec	17. Father's Name (First, Middle, La	st)				18. Mother's Ner	ne (First, Middle, M			
tic e	10	Daniel	- Hersl	hberg	er		Mary		Ho1	Lmuth	
5		19a. Informent's Neme/Relationship				g Address (Street		ral Route Number,		DELLINE, MAY ME MAN.	de)
er tra		Jonas D. Kinsin	ger/ Husbar	nd	8004	Garret	t Highway	, Oaklar	nd. MD	21550	
nt: If item ry or oth		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐Removal from State	20b. I	Place of Dispos cemetery, crem	atory or other pla	ce)		0c. Location -	City or Town,	State
Inju	1	21. Signature of Funeral Servica Lic		116.					alisbu	rg, PA	
any Ir		K M. O.	-an				ess of Facility Ineral Ho				
		23a. Part 1. Enter the disease, or co shock, or heart failure. List or	empilcetions that couse	ed the deat	th. Do not ente	S. Seco	ond St.,	Oakland,	MD 215		proximate
cian lical		Immediate Ceuse (Final						or respiratory ene		Int	erval Between eset and Deeth
niner		disease or condition resulting in death)	aA			dial Inf	arction			mi	inutes
	6				or es a consequ						
Insit	Examiner	Alman	■ bA		scleros					- 1	10 years
T-T-	Exa	Sequentially list conditions, if any, leeding to immediate		Due to (d	or as a consequ	ienca of):				i	
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dateched	Physician/M	Part II. Other significant conditions	contributing to death	but not res	suiting in the un	derlying ceuse giv	ven in Part I.		.6.		cause of death?
	by P	Prior Acute In	ferior Myo	cardi	al Infa	arction	1996	1 🗆 Ya	2 Q No	3 Probabi	ly 4 🗆 Unknown
	Completed	Hypertension, U	ndifferent	iated	schizo	phrenia		performed? aveilable			autopsy findings ble prior to etion of cause
rector, page 2	E							1 ☐ Yes	2 No		es 2 No
	BeC	25. Wes case referred to medical					26 Place of Dog	th (Check only one	1	10.16	2 2 140
	108	examiner? 1 ☐ Yes 2 No	Hospitel:	iont 2	ER/Outpetient	ard poor Oth		ome 5 Residen		(0	
50		27. Manner of Death	28a. Date of Inju	ury	28b. Time of	3 DOA 28c. Injur	4 LI Nursing H	28d. Describe hov			
fun	<u> </u>	1 Natural 5 Pending investigat	(Month, Da	ay Year)	Injury		rk? Yes 2 □ No		, ,		
d in by the	Certification:	3 Suicide 6 Could not determine		281. Location (Street and Number or Rural Route Number, City or Town, Stete)							
complately filled in by the funa	edical C	29a. Certifier (Check only one) Certifying F	Physician: To the best aminer: On the basis of and manner st	r examine	wledge, death tion and/or Inve	occurred at the tir estigation, in my o	me, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and me e and place, a	enner as stated and due to the	i. cause(s)
To the Funeral I complately filled	-	29b. Signature and title of certifier		1		29c. Licens	e number	290	d. Date signed	d (Month, Day,	, Year)
		* Margar	etas	Lai	u		29d. Date signed (Montal 2006) 2/21/99				
				donth (ttor	22a) (Time D	nlma)					
		30. Name and eddress of person wh Margaret A. Kais				Oakland,	MD 215				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Month 19, 1999 January 12:30PM Cecelia Lorraine Katinsky 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 401 Wrights Avenue Hurlock Dorchester If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Pay, Year)
Aug. 12, 1922

8. Birthplece (Stete or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Deys Hours Months 1□M 20XF Yes 76 213-12-4288 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No Maryland Dorchester **Hurlock** 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 401 Wrights Avenue 21643 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White Yeer or Detes: 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Christopher Raymond Maguire Maria Hilda Sinnot 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John Katinsky/Husband 410 Wrights Avenue, Hurlock, Maryland 21643 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetton 5 ☐ Other (Specify) Unity Washington Cemetery1/22/99 Hurlock, Maryland 21. Signature of Fungent Service Liq Zeller Funeral Home, P. O. Box 207, 106 Main Street, East New Market, Maryland21631 Inter the disease, or commications that mused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause meeth line. Approximete Interval Between Onset and Deeth Myocardial Infarction Immediate Causa (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last Due to (or es e consequenca of): Due to (or es e consequence of): Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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signed by t

page 2 has

> director, Be

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified

Completed

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Certification:

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Box 68760.

P.O.

Records.

Division of Vital

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Physician

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r than "natural", or items 23e or 28e-f show the Medical Exeminer must be notified at

Herris 23a or

al Hygiece.

permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, importants if New 27 is marked other any injury or other.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ

24e. Wes en eutopsy performed? 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of deeth?

1 ☐ Yes 2 No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 No 27. Manner of Deeth

1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Yes 2 No

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Neturel 5 Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

281, Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier

Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

JAN 22 1999

29c. License number

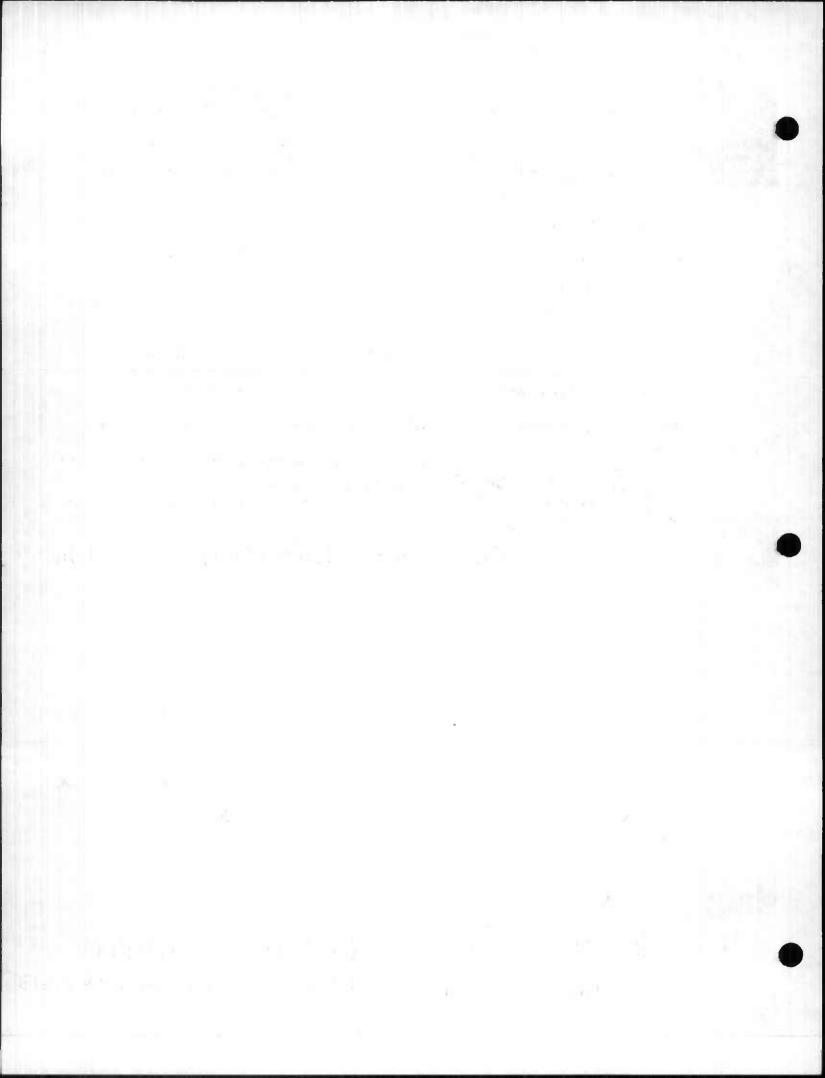
29d. Dete signed (Month, Dey, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Franklin X. Cambridge, mo 21613

Will ram 31. Dete filed (Month, Day, Year)

32. Registrer's Signeture

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death **Physician** Month 10.05pm Lucy Louise Kronlund 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva straat and number) Examiner St. Mary's Hospital St. Mary's Leonardtown if Undar 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1□M 2 F Days June 14, 78 Yrs. Maryland 226-12-2765 Usuai Basidanca of Dacedant 10c. City, Town or Location 10d. Insida City Limits 10e. Stata 10b. County 1 Yas 2 No Directo Boca Raton Flordia 10e. Street and Number 10f Zin Coda 10g. Citizan of Whet Country? 2171 E Silver Palm Road 33432 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Raca - Amarican Indian, Black, Whita, atc. 13. Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Nevar Marriad 2 Married 1 Yas 2 No Specify: by 3 N Widowed 4 Divorced White Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16h. Kind of Business/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) 12th Co Owner Air Condition 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maidan Sumama) Lucy Adelaide Burroughs Samuel Bernard Burch, Sr. 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 38198 Lockes Crossing Rd., Mechanicsville, MD 2065 Samuel B.Burch, JR. Brother 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematery, crametory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 1/18/99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 22. Nama and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. Part1. Enter the diseased or complice shock, or heart failure. P.O. Box 270, Leonardtown, Maryland 20650 of or complication that causad the doubt Do not anter tha moda of dying, such as cardiac or raspiratory arrast, Approximata intarval Between Onsat and Daath Immediata Causa (Final disaasa or condition rasulting In daath) CONGUSTIVE Hanry FMWRE Dua to (or es e consaquance of): Physician/Medical Examiner ATRIM FIBRILLMON Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequenca of): Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown PROSSURE Hyprocepitans þ 24b. Were autopsy findings avallabla prior to 24a. Was an autopsy performed? Completed ELECTROWITE IMBorne? complation of causa of death? 1 ☐ Yas 2X No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 Dinpatiant P 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? Certification: 1 Netural 5 Panding invastigation 1□ Yas 2□No 2 Accident 6 Could not ba 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, daeth occurred et the time, dete end plece, and dua to the cause(s) end manner es stated.

2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred et the time, data and place, and dua to the causa(s) and manner stated. edical 29a. Cartifian (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)

Box 68760. P.O. Division of Vital Records,

The law requires that

To the Hospital or Attending

LUCY LOUISE KRONLUND

/Medical

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or ther any injury or other traumatic event, the Medical Evan

Physician /Medical

Examiner

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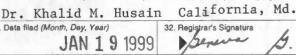
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Baltimore, Maryland 21215-0020

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State Registrar 31. Data filad (Month, Day, Year) JAN 1 9 1999



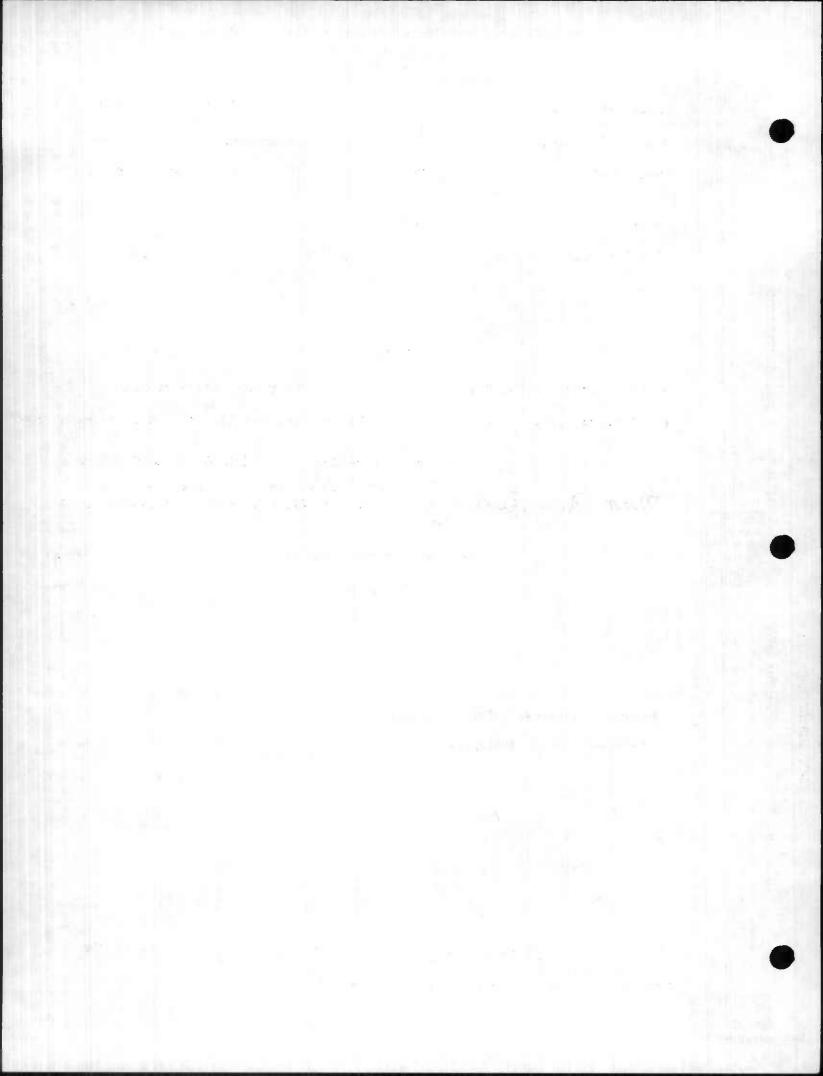
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30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wanda Helen Lange 1999 20 January 9:46 AM '/Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Months Deys 77 556-22-3347 12, 1921 Director California Oct. Usual Residence of Deceden 10e State 10c. City, Town or Location 10d. Inside City Limits 10h County 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Ann apolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1225-H Gemini Drive USA Funeral 21403 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Hanany Injury or other traument. 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: Specify: þ 3 K Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Irving Gregg Nellie Kuntz 19a. informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) D. Gregg Lange / Son 979 Headwater Rd. Annapolis, Md. 21403 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurlet 2 Cremetion 3 Removet from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 1-22-99 Annapolis, Md. 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signeture of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, man) 23a. Part1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 12 Hypotension Examiner Due to (or as a consequence of) Examiner 18 gastric end burial-tran Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting In deeth) Lest Due to (or as a consequence of): ulcar disease 5 physician Physician/Medical the Due to (or as a consequence of): gastroutestural for use es ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 12 Yes 2 No 3 Probably 4 Unknown heart disease osclerotic Completed by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this cartific. director. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Inpatient Certification: To 2 ER/Outpatient 3 DOA funerel 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1/2 Netural tniun 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Coutd not be determined 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29e. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number

landy 20

State Registrar 30. Neme and address of person who comp

Date filed (Month, Day, Year)

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eted cause of death (Item 23e) (Type, Print)

32. Registrar's Signeture

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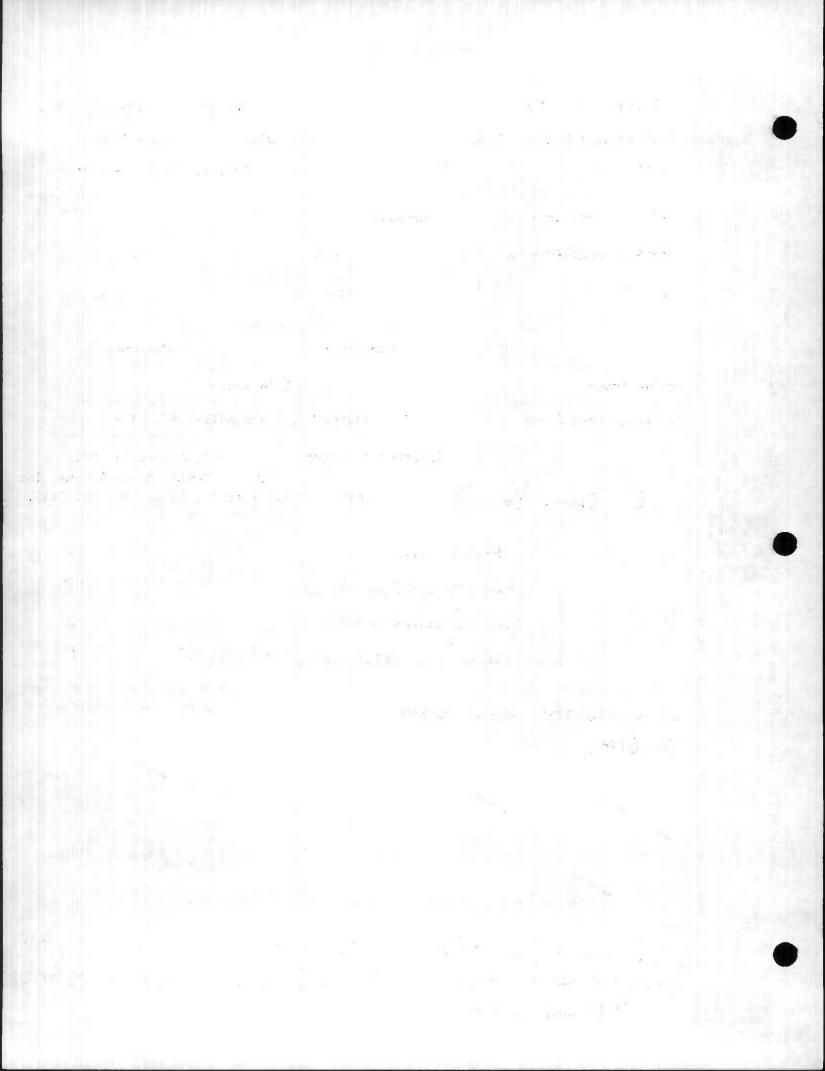
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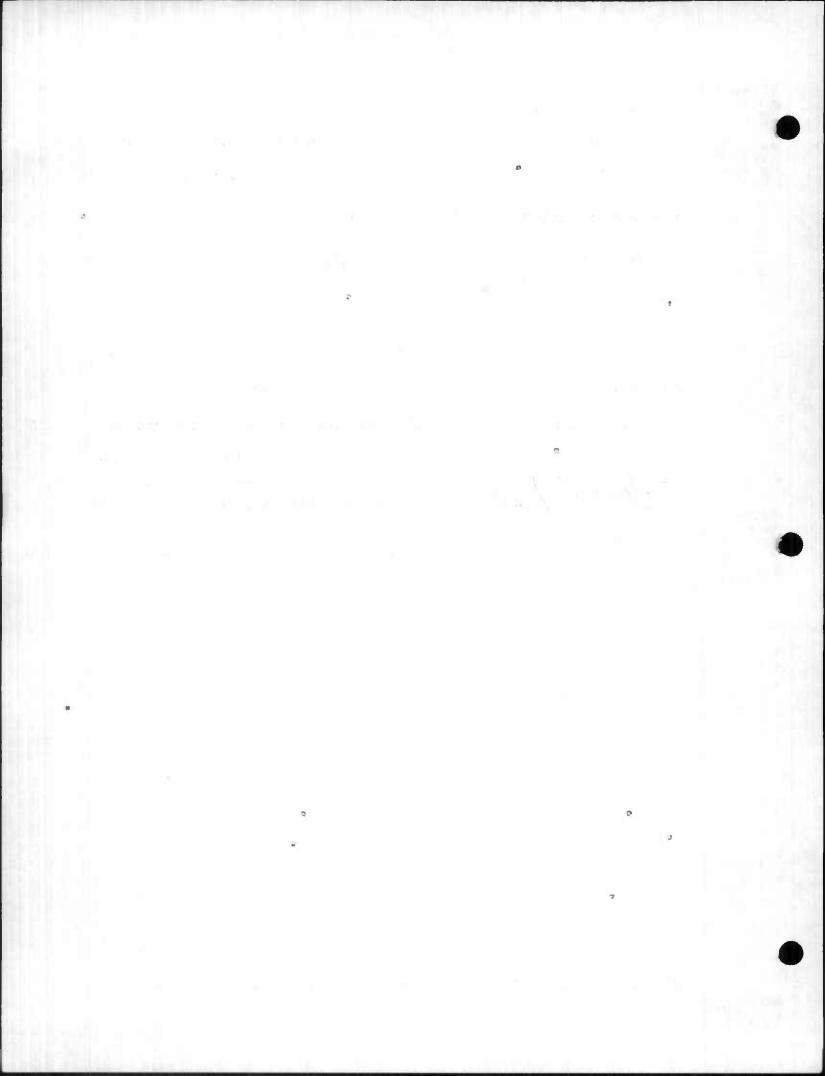
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Division of Vital



State of Maryland / Department of Health and Mental Hygiene 99 02801

						Certific	cate of	Death		Re	g. No.		U Las	
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	Physic /Medi		Mary G. La	wler						uary	15, 19	Year 999	1:	10 pm
	Exami		4a. Facility Name (If not institution, gi	ve street and number)				4b. City, To	wn, or Location		4c. County			TO DAIL
É	Exami		Bayside Nursing						gton F		st. N	Mary's	5	
	Funeral Director	ŀ		1□M 2■E	(In yrs. last bi	Yrs. H U	nder 1 Year ths Days		Min. (M	te of Birth onth, Day, wary 1.		9. Birthp Coun Penns	itry)	ania
	how how		10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits		
	e Ma	cto	Pennsylvania Mo	ntgomery	Lafay	ette H	ill		1 ■ Yes					Yes 2□No
	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show its Medical Examiner must be notified at	Director	10e. Street and Number			10	. Zip Code			10	g. Citizen of	What Coun	itry?	
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21215-0020	ours afte	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 € No If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ■ No						y Whit		
5-0	in 72 ho	Completed	15. Decedent's E (Specify only highest gi	ducetion	16a	. Decedent's	Usual Occu	pation	of working	1	16b. Kind of Business		Justry	
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3	should be and Mental a marked of umatic eve	2	Francis Knoll					<u> </u>	Clara	Schne	epf			
Jar			19a. Informant's Name/Relationship	Type, Print)	198	o, Mailing Add	iress (Stree	t and Numbe	r or Rural Rout	e Number,	City or Town,	State, Zip	Code)	
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altimore,	permit. Pages 1 a Department of Hee Important: If Item any injury or otha once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci		cemate	of Disposition on, cramatory Cy Ceme	or other pla	ice)	1-20		ower M			
alt	Departr Importa any Inju		21. Signature of uneral Service Life	nsee/		22. Nam	e and Addr	ess of Facility	Brinsf	ield	Funera	al Hor	ne. 1	РΔ
m	205 2 2		Edward N. Brin	stield, Jr.	M00052	2295	5 Hol	ادسما	Rd., I					
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused t	he death. Do	not antar tha	mode of dyl	ing, such as	cardiac or respi	ratory arre	st,	ב לבויין	Approxi	mate
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r			Immediate Cause (Final disease or condition resulting in death) a. Car obstructive Juliu sureaste								920	9	70068	
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	eath certificete be executed attending physician and for use as the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasi Due to (or as a consequence of):									1		
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of	Physic this c	2	1 ☐ Yes 2 ■ No	Hospital: 1 Inpatien	t 2 ER/O	utpatient 3	DOA		rsing Home 5	Resida	nce 6 Oth	er (Specify	1)	
	fter t	on:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day		Time of Injury	28c. Inju Wo	ny at	28d. D	escribe ho	w Injury occur	red		
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Division	i or Att after d Direct d in by	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	ctory, office	ce 28f. Location (Street and Number or Rural Re City or Town, State)					l Routa M	√um <i>ber</i> ,			
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	edical C	29a. Certifier 1 Certifying Pl	red at the ti	me, date and opinion, deat	d place, and du h occurred at th	e to the ca ne time, da	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)						
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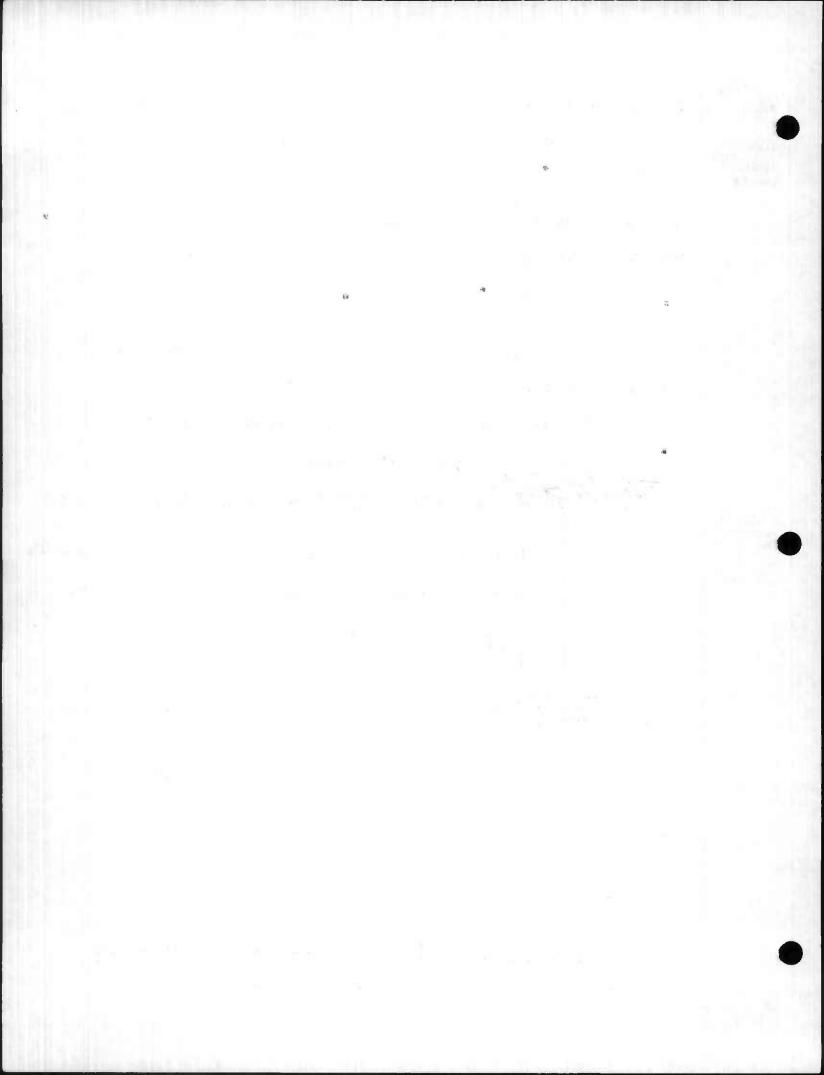


State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Carl Marx Loffler, Sr. 1999 January 18, 11:00 A.M /Medical 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown H Undar 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Ye If Under 1 Year Months | Days 9. Birthplaca (State or Foreign Country) Washington, DC 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 ■ M 2 □ F Yrs 86 June 4, 579-03-1805 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. inside City Limits rai', or items 23a or 28a-f show Exerciner must be notified at 1 ☐ Yes 2 ■ No Director Maryland St. Mary's California 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 46150 East Sunrise Drive 20619 United States death Funerai 12. Was Dacadent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examina 1 ☐ Nevar Married 2 ☐ Married I ☐ Yes 2 ■ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: Specify: Completed by 3 ■ Widowed 4 Divorced White 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Charles Loffler, Sr. Emily Nikl 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 400, Hollywood, Maryland 20636 Charles Loffler, II Son 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ■ Burlai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-23-99 Gedar Hill Cemetery Suitland, Maryland 22. Name and Address of Facility Brinsfield, Jr. Brinsfield Funeral Home, P.A. Edward N. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Intervai Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner croway astery ician and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. physician the buna 88 esn signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were autopsy findings available prior to Completed 24e. Was an autopsy performed? completion of cause of death? page 2 certificate 1 Yas 2 No 1 Yas 2 No Division of Vital or Attending Physician: 25. Was case reterred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20 No this funeral 27. Menney of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? After 5 Pending investigation 1 Naturel n 24 hours after death.

• Funeral Director: Att 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner as steted. To the Hosp within 24 hor To the Fune completely fi Medicai (Check only one) 2 Medical Examiner: On the besis of examinetion and/or Investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 1.20.9 001380 30. Neme end e ress of person who completed cause of deeth (Item 23e) (Type, Print) Leonardtown, Maryland 20650 John Fenwick, M.D. 31. Date filed (Month, Day, Year) JAN 22 1999 32. Registrar's Signature State

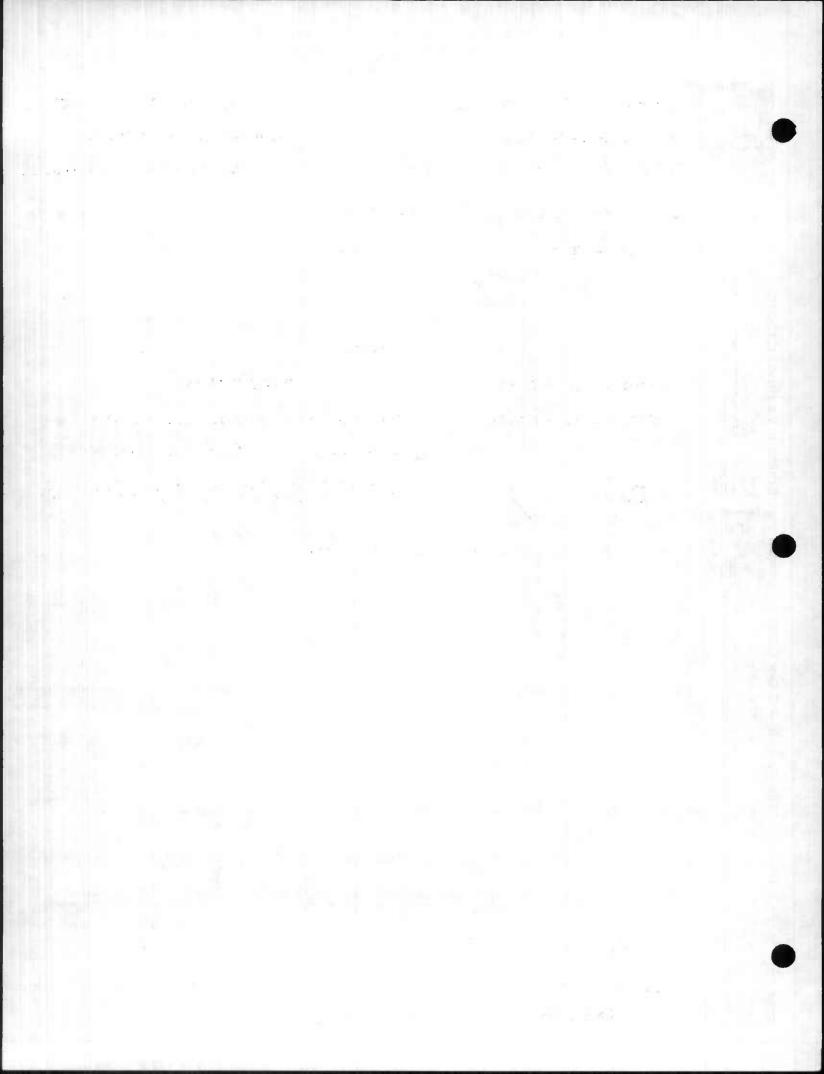
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Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 17, 1999 **Physician** McCarron Thomas Patrick January 4:50 am /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not Institution, giva street and number) Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, May 15, 5. Social Security Number 213-38-0126 7. Age (In yrs. last birthday) **Funeral** Min Y9940 1MM 2□ F Months Days Hours Washington, DC 58 yrs. Director Usual Residence of Decedan with the Maryland 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show say in Jury or other treumatic event, the Modical Examples man be indiffied at once. 10a. Stata 10b. County 10c. City, Town or Location Millersville MD Anne Arundel 1 ☐ Yas 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 121 Fordham Drive 21108 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 월 No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married White altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kInd of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) College (1-4or 5+) Attorney Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Dorothy Williams Vincent Joseph McCarron 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Phyllis McCarron / wife 121 Fordham Drive, Millersville, MD 21108 20b. Place of Disposition (Nama of cemetery, crematory or other place) Jan 20 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State Annapolis, MD Hillcrest Cemetery 1999 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility
Barranco & Sons, P.A. Severna Park Funeral Ho 495 Gov. Ritchie Hwy., Severna Park, MD 21146 21. Signature of Funeral Sarvice Licensee Kelli-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical SMALL CALL CALCINOMA Examiner Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of). 80 950 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 6 signed b p 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed need page 2 s certificate has 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 No 2 ER/Outpetient 3 DOA After this 28a. Date of tnjury (Month, Day Year) funeral 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 1 Natural 5 Pending after death. Director: Aft 1 Yes 2 No invastigation 2 Accident n 24 hours after dea ne Funeral Director cletely filled in by th 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide ò Hospital 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted. edical To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. (Check only one) 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifiar D21336 9 30. Name and address of person who completed ceuse of death (ttem 23a) (Type, Print) 8028 Gov. Ritchie Hwy., Suite 134, Pasadena, MD 21122 Allen Kuhn, M.D., 31. Dete filad (Month, Day, Year) 32. Registrar's Signeture State JAN 2 0 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) JANUARY 16 Mc GEE 330 Am 1999 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, give street and number) Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthpiace (State or Foraign Country)

June 6, 1913 N. Carolina 7. Age (In yrs. last birthday) 12 M 2□ F Days 578-10-2053 85 Yrs. Usual Rasidenca of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits Anne Arundel Annapolis 1 Yas 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 893 Chestnut Tree Drive 21401 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - American Indian. 11 Maritel Status 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Datas: 1 Never Merried 2 Married White 1 Yas 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Washington Star Elamentary/Secondary (0-12) Collega (1-4or 5+) Newspaper Route Agent 12 17. Father's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middla, Maldan Sumeme) John McGee Ida Crenshaw 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Lawrence McGee / son 893 Chestnut Tree Drive, Annapolis, MD 21401 Deta 19 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition Tan 1 Buriei 2 ☐ Cremation 3 ☐ Removal from Stata Brentwood, MD Ft. Lincoln Cemetery 1999 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funerel Sarvice License 22. Nama and Addrass of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 23a. Part1. Enter the disease, or complications thei caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disease or condition resulting in deeth) Sep5(5)
Dua to (or as a consequence of): Oneumoniaepheumonia Due to (or es a consequence of): xacerbatia Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 19108 2 No 3 Probably 4 Unknown 24b. Ware eutopsy findings available prior to 24e. Was an autopsy complation of causa of daath?

Physician /Medical **Examiner**

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certificate has b lirector, page 2 s

After this

after death.

24 hours

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Hospital or Attending

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Certification:

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P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

10a Stata

MD

Director

Funeral

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Funeral

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r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

aith and Mental Hygie 27 is marked other in traumatic event, it

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any lollury or other traumatic event place.

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death

filed within 72 hours after

Physician/Medical Examiner Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Diseese or Injury that initiated evants rasulting in daath) Last

28. Placa of Deeth (Check only ona)

2 7 No

28d. Dascribe how injury occurred

1 ☐ Yas 2 ☐ No

25. Was cesa refarred to medical axaminar? 1 Yes 2 No

5 Panding investigation

6 Could not be

Hospital:

28a. Data of Injury (Month, Day Year)

1 ☐ Impatient 2 ☐ ER/Outpatlent 3 ☐ DOA

28a. Place of injury - At homa, farm, streat, factory, office building, atc. (Spacify)

Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28c. Injury et Work? 1 Yas 2 No

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29e. Certifier (Check only one)

27. Mannar of Death

1 Maturel

2 Accident

3 Suicida

4 | Homicide

1 Certifying Physician: To the best of my knowledge, daath occurred et the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number

29b. Signatura end titia of certifian

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed ceusa of daath (Itam 23a) (Type, Print)

1 2001 Winding Creek and bermantoun, mo 20874 Mohames S.

Registrar

JAN 1 9

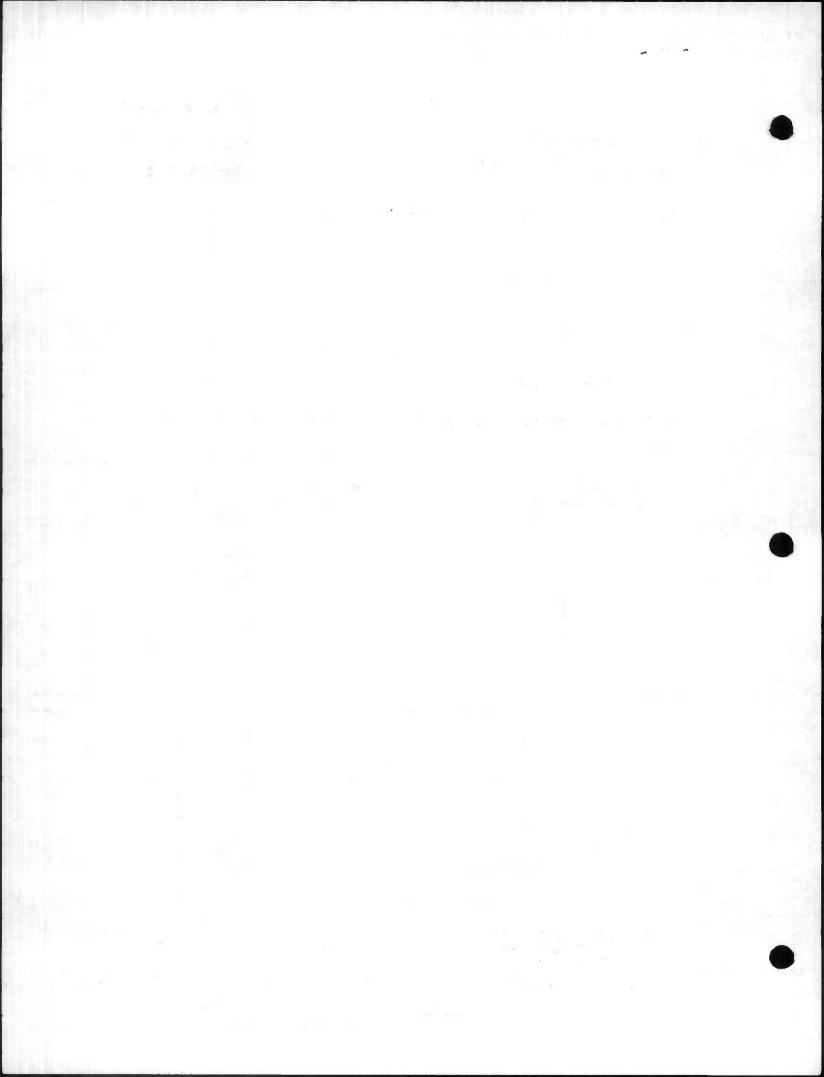


State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 21,1999 Estelle Mills Mary 1:15 AM January /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dorchester Dorchester General Hospital Cambridge If Under 1 Yaar If Under 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** 1 □ M 2 🕱 F Mar Vland Yrs. 88 214-07-7031 Director Usual Rasidance of Decedent 10a State 10b County 10c. City, Town or Location 10d. inside City Limits Maryland Dorchester Cambridge WAYes 2□No Director r than "natural", or litems 23a or 28a-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? US 317 Belvedere Avenue 21613 Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas XX No Specify: White þ 30 Widowed 4 □ Divorced Completed 15. Decedent's Education 18a. Decedent'a Usuai Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w.
Department of Health and Mental Hygien important: if flem 27 is merked other tha any finury or other traumetic. Office Worker State Government 17 Fathar's Name (First Middle Lest) 16. Mother's Name (First, Middle, Maiden Surname) Be .John Roberson Minnie Estelle Beckwith Frank 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Beckwith Roberson 817 Locust Street Cambridge, Maryland 21613 Brother 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata XX Buriai 2 Cremation 3 Removal from State Dorchester Memorial Park 1/23/99 Cambridge, Maryland 4 □ Donation 5 □ Othar (Specify) 21. Signatum of Funeral Service Licensee 22. Name and Address of Facility
Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Parti. Enter the disease, or complications that caused tha deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, allock, or haart failure. List only one cause on each lina. Approximata Interval Batween Onset and Death **Physician** Aurie Cardio pulmonary arrest. /Medical tmmediate Cause (Finei disaasa or condition resulting in death) Examiner Examiner Aoutic value replacement 3talus post ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician as the burial Records, P.O. Box 68760, Physician/Medical ed by the attending detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown à page 2 should b 24b. Were sutopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? 1 Yes 20 Ne. 1 Yes 2 No. certificata Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 | Yes 2 | No 10 2 A ER/Outpatient 3□ DOA apital or Attending Physhours after death.

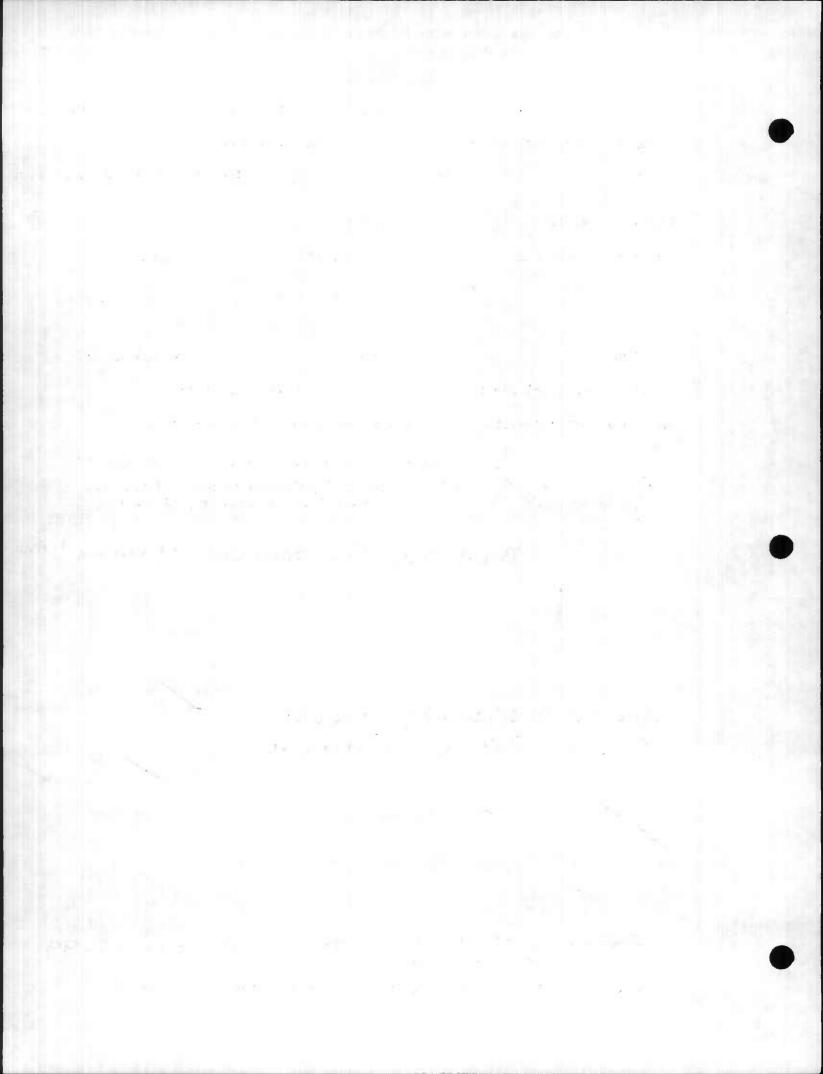
neral Director: After this y filled in by the funeral di After this 27. Manner of Death 1- Natural 28c. Injury at Work? 28a. Date of injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1/22/99 30, Name and address decision who completed cause of death (Item 23a) (Type, Print) street Cambridge MO21613 105 Aurora Nawaz 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey **Physician JOHN** HOWARD MATTINGLY JANUARY 15, 1999 1007 a.m. /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 6. Sex 1 2 M 2 ☐ F if Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 68 Director October 18, 1930 Washington D.C. 577-34-7101 Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itema 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 No Maryland Directo Calvert Lusby 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 11316 Commanche Road 20657 U.S.A. Pages 1 end 2 should be filed within 72 hours effer death tent of Health end Mental Hygiene.

nt: If item 27 is marked other than "natural", or itema 23. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Type 2 No Specify White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Forman Telephone Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Howard Mattingly Sr. Dola Rosa Benson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary June Mattingly/Wife 11316 Commanche Road, Lusby, MD 20657 item 2. 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or pace. = 8 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 1/18/99 Bushwood, MD 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Lice P.O.Box 270, Leonardtown, MD 20650 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** PNEUMONIA Lucek /Medical Immediate Cause (Final SEUDOMONAS disease or condition resulting in death) Examiner Examiner lew requires that the death certificeta be axecuted attending physician and for use es the bunal-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? signed by the ACUTE RESPIRATORY ter Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to Completed RENA 24a. Was an autopsy performed? completion of cause of death? certificata has t irector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attanding Physician: 24 hours after daath. Funeral Director: After this certifica stely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No Certification: To 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? 5 Pending Investigation 1 Natural 1 Tes 2 No 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide A 24 hou. the Funeral Directory 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi Medical 29d. Date signed (Month. Dav. Year) 29b. Signature and title of cartifier 29c. License number 2 PW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.A. Shah 100 Hospital Road, Prince Frederick, MD. M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 9 1999 Registrar



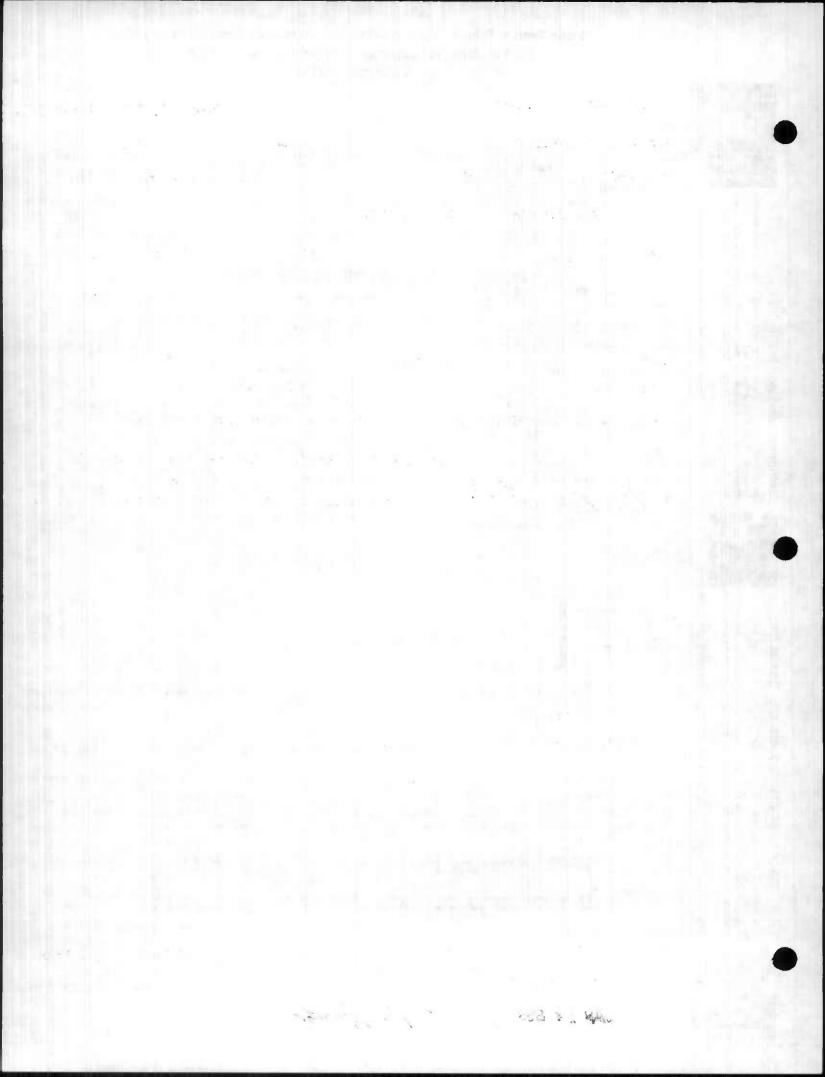
State of Maryland / Department of Health and Mental Hygien

Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death **Physician** , 22 Am FRANKLIN WILLIAM NEUMANN, SR. 18 Januar /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen BURNIE ar If Undar 24 Hrs. 8. D ANNE HRUNDEL If Undar 1 Yaar 5. Social Security Number Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) Year) 12 M 2 F Months Days Hours Min. Yrs. 214-12-8317 76 SEPT 23, 1922 Director MARYLAND Usual Rasidence of Decedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 X No Directo MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda "natural", or items 23a or 4 GILMORE STREET 21061 U.S.A. Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 1 Yas 2 XNo Specify: by 3 XWidowed 4 ☐ Divorced WHITE or than "nature Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamentery/Secondary (0-12) Collaga (1-4or 5+) Hygiena. ELECTRICIAN BENDIX CORPORATION 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pages 1 end 2 should be finent of Haalth and Mantai Fint. If item 27 Is marked ot JOHN W. NEIMANN FRANCES PLICTA 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) DELORES WELCH (DAUGHTER) 316 NORTH CAROLINA AVENUE, PASADENA, MARYLAND 21122 20b. Place of Disposition (Nema of camatary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata important: If it any injury or o 1 Buriai 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) CEDAR HILL CEMETERY 1/21/99 BROOKLYN PARK, MD 22. Nama and Addrass of Facility
SINGLETON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 23a. Part1. Enter the diseaser or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onsat and Death **Physician** SEPSIS /Medical Immediata Causa (Final WEEKS TWO disaase or conditio rasulting in death) Examiner Due to (or as a consequence of): Examiner physician end the burial-transit the death certificate be axecuted Sequantially list conditions, if any, laading to immadieta cause. Entar Underlying Ceuse (Disease or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): 88 USB ō Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? asculi tis 1 Yes 2 No 3 Probably 40 Unknown by Ped P 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy complation of cause of death? certificate has t 2 No 2 No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA this 28d. Dascribe how injury occurred 27. Mannar of Deeth 28h Tima of 28c. Injury et Work? or Attending Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicide hours a 24 hours Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and dua to the cause(s) and manner es stated.

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State of Maryland / Department of Health and Mental Hygiene 99 02808 Certificate of Death

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İ	Funeral Director	5. Sociel Security 218-07-0	Number 6. \$		(In yrs. last bii 1	thday) If Under 1 Yea Months Deys	r If Under 24 Hrs.	8. Date of Birth (Month, Dey	Allega Year) 14, 191	9. Birthple Country	ce (Stete or Foreign	
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Division	To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 ☐ Sulcide 4 ☐ Homloide	6 ☐ Could not be determined	28e. Plece of inju building, etc.	ry - At home, fe (Specify)	erm, street, fectory, offic	ө		ion (Street and Number or Rural Route Number, r Town, Stete)			
	thin 24 hours thin 24 hours the Funeral mpletely fille	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of niner: On the basis of end menner stat	examinetion er	e, deeth occurred et the id/or investigation, in my	time, dete end plece opinion, deeth occu	e, end due to the durred et the time, d	euse(s) end me dete end piece,	enner as ste and due to t	ted. he cause(s)	
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State of Maryland / Department of Health and Mental Hygiene O

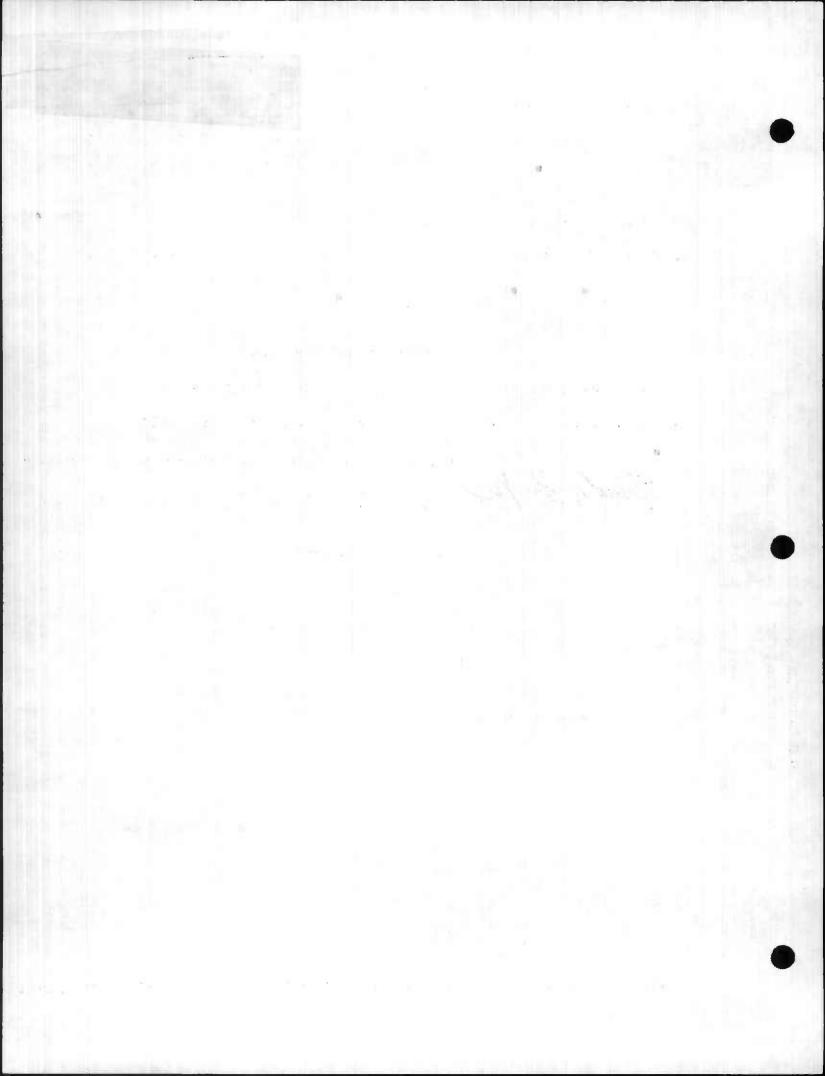
Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Donald Charles Rowand, Sr. 1999 January 14 6:44 PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner St. Mary's St. Marys Hospital Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year).

Months Deys Hours Min. September 11, 1939 Birthplace (State or Foreign Country)
 Texas 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ■ M 2 □ F Yrs. 464-58-2558 59 Director Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Modical Examinar maint or nothed at 1 ☐ Yes 2 ■ No Director Maryland St. Mary's Dameron 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 20628 United States 18072 Trossbach Road death Funerai 12. Was Decadent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1958-1962 72 hours efter 1 ☐ Never Married 2 ■ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Aircraft Mechanic Manager Defense 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f Julia Agatha Skorupinski Charles Shumway Rowand 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 to Department of Health an Important: If Item 27 is 1 any Injury or other traus P.O. Box 2, Dameron, Maryland 20628 Wife Teresa A. Rowand, Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Buriel 2 Cremetion 3 □ Removal from State Charles Memorial Gardens 1-18-99 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of General Service Liponale Maria N. Brinsfield, Jr. 22. Name and Address of Fecility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset end Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Myocardin INFARUTIO He. Examiner Due to (or es e consequence of) NSYM Examiner HYPORTONTIN attending physician and for use es the burial-transit DONALD CHARLES ROWAND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) CORONTMY moran MASMIT Box 68760 certificate be Physician/Medicai Due to (or as a consequenca of): ITY PORCUPIDEMIA death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? the the signed by 1 Yes 2 No 3 Probably 4 Unknown that SMOKING MISTORY é Records, 8 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peens completion of cause of death? certificate hes page 2 The 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Wes case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpetient 2 B ER/Outpetient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b Time of 28c. Injury at Work? Certification: Attending 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident the 24 hours efter deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 6 edicai 29e. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the ceuse(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D34539 1. 16.99. 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) KHALID M. HUSAIN M.D. BRENTON MEDICAL 22576 McARTHUR BLVD.SUITE 354 CALIF.MD.20619 31. Date filed (Month, Day, Year) 32. Registrar's Signature outs

DHMH 16 Rev 6/95

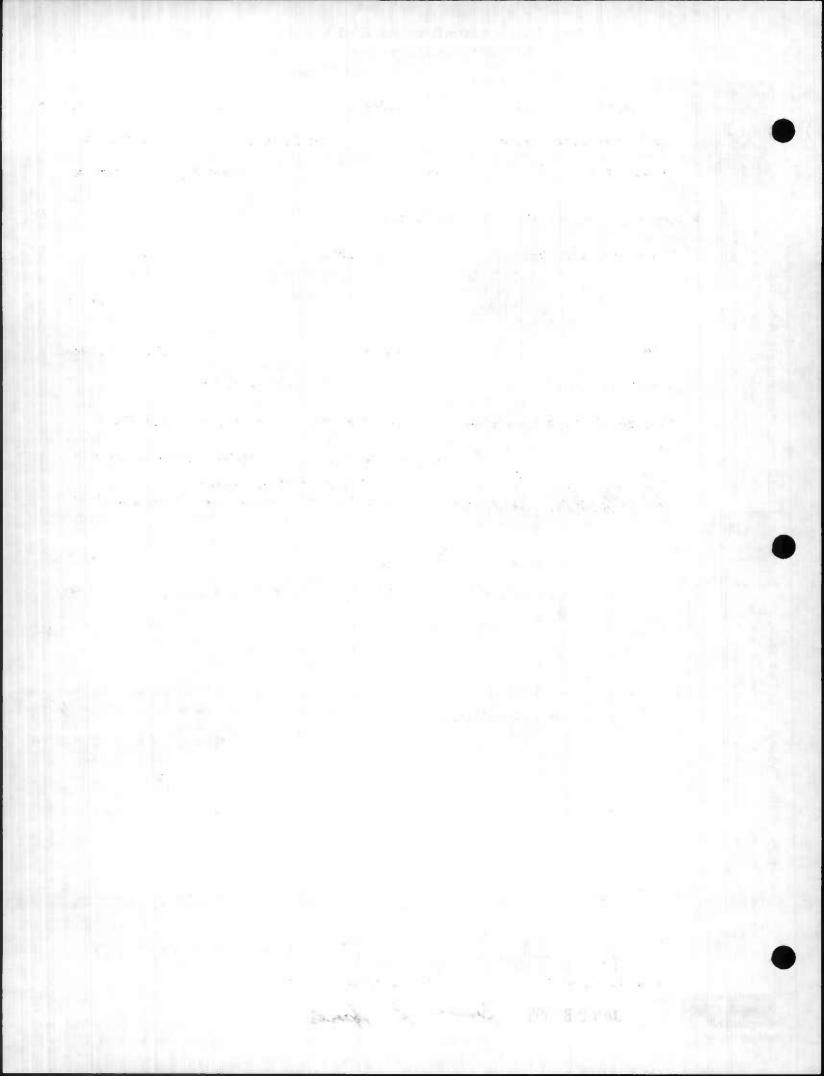
Registrar

JAN 1 9 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 6:30 A Mande Sachs Jan /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health of Glen Burnie Anne Arundel Glen Burnie 9. Birthplace (State or Foreign Country) West Virginia 5. Social Sacurity Number 7. Age (in yrs. last birthday) **Funeral** 1□M 2MF Months Yrs. 84 166-58-7882 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Matical Examiner must be notified at 1 ☐ Yas 2 No Glen Burnie Directo Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 United States 1544 Hodges Avenue Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Yaar or Dates: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than eny injury or other traumatic avent, it is the eny injury or other traumatic avent, it is the Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middla, Maiden Sumame 17. Father's Name (First, Middle, Last) Frances Yoak James Shriver Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, Maryland 1544 Hodges Avenue Jeanne Shaffer Sister 20b. Place of Disposition (Name of cematary, cramatory or other place).
Chesapeake Cremation
Center LLC. Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-20-99 4 ☐ Donation 5 ☐ Other (Specify) Chester, Maryland 21. S seature of run all S vice Licensee 22. Name and Address of Facility eny ir SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 23a. Part 1. Entar the disaasa, or com shock, or heart failura. List only Approximata Interval Batween Onset and Death lications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne causa on each line **Physician** Immadiata Cause (Final diseasa or condition rasulting in death) Wholes /Medicai poal noma Examiner Due to (or as a consequenca of): Examiner attending physician end for use es the buriel-transit Sequentially list conditions, if any, laading to Immediata cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Physician/Medical Due to (or as a consequence of). Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa ratarred to medical examiner? Be 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1□ Yes 200 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Tima of 28c. Injury at Work? Certification: 24 hours effer deeth. Funerel Director: After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Sulcida 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) filled in by 4 ☐ Homicida edicai 29a. Certifie 1 Cartifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and dua to tha causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Data signad (Month, Day, Yaar) 29b. Signature and the of certified Jan 19 1999 D44973. 21061 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) GURMEET.S. SAWHWEY MD 325 HOSPITAL DRIVE GLEMBURNIE MD

Registrar

31. Date filed (Month, Day, Year)

JAN 2 1 1999

32. Registrar's Signature

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Peges 1 and 2 should be filed within

The law requires that the deeth certificate be executed

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certificate Physician:

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Division of Vital Records, P.O. Box 68760,

Manche Sach



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) January 23, 2:00 P.M. CHARLES WERNER SHUFFLE 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) St. Mary's St. Mary's Hospital Leonardtown 8. Date of Birth (Month, Dey, Yeer)
Dec. 8, 1914 If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country)
District Columb 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) Months Days Hours 1QM 2□F Yrs. 84 577-03-1393 Usual Residence of Decedent 10e State 10b County 10c. City. Town or Location 10d. Inside City Limits Yas 2□ No Sussex Delaware South Bethany 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Coda 136 New Castle 19930 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien. 11 Maritel Status Black, Whita, etc. 1 Never Married 2 Merried Specify: White 1 No Specify: 3 ☐ Widowad 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Health Care Podiatrist 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Shuffle Maude Hovermale Carrie Edwin 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 45211 3231 Pickbury Drive, Cincinnati, Ohio Sue M. Allenspach (daughter) 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, Stete 1 Buriei 2 Cremetion 3 Ramoval from Stata 1/24/99 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Zaud N Brinsfield Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrast, shock, or haert failure. List only one cause on each line. Approximate Interval Batween Onset and Deeth Immediate Cause (Final disease or condition resulting in death) YRS Due to (or es e consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) that initiated events resulting in deeth) Lest Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 ☐ Yes 2 No 25. Wes case referred to medical axeminer? 26. Place of Death (Check only one) Hospitei: 1 ☐ Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760, 24 hours after death. The lew requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicien and letely filled in by the funeral director, page 2 should be deteched for use as the bunal-transit

Certification: To Be Completed by Physician/Medical Examiner

Physician

· /Medical

Examiner

Director

Funeral

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Completed

Be

10

Funeral

Director

7 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Medical Expresser must be notified at

2 should be filed within 72 hours efter end Mental Hygiene. Is marked other than "natural", or its

permit. Peges 1 end 2 st Department of Health end Important: If Item 27 Is n any Injury or other traun once.

Physician

/Medicai

Examiner

Baltimore, Maryland 21215-0020

the Maryland

29a. Certifier (Check only one)

31. Dete filed (Month, Dey, Year)

building, etc. (Specify)

Critying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated.

Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred at the time, dete and piece, end due to the cause(s) end menner stated.

29b. S form the of certifier And Torus

29c. License number

29d. Dete signed (*Month*, *Dey*, *Year*)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

William D. Boyd 11, 25365 Point Lookout Road, Leonardtown, MD 20650

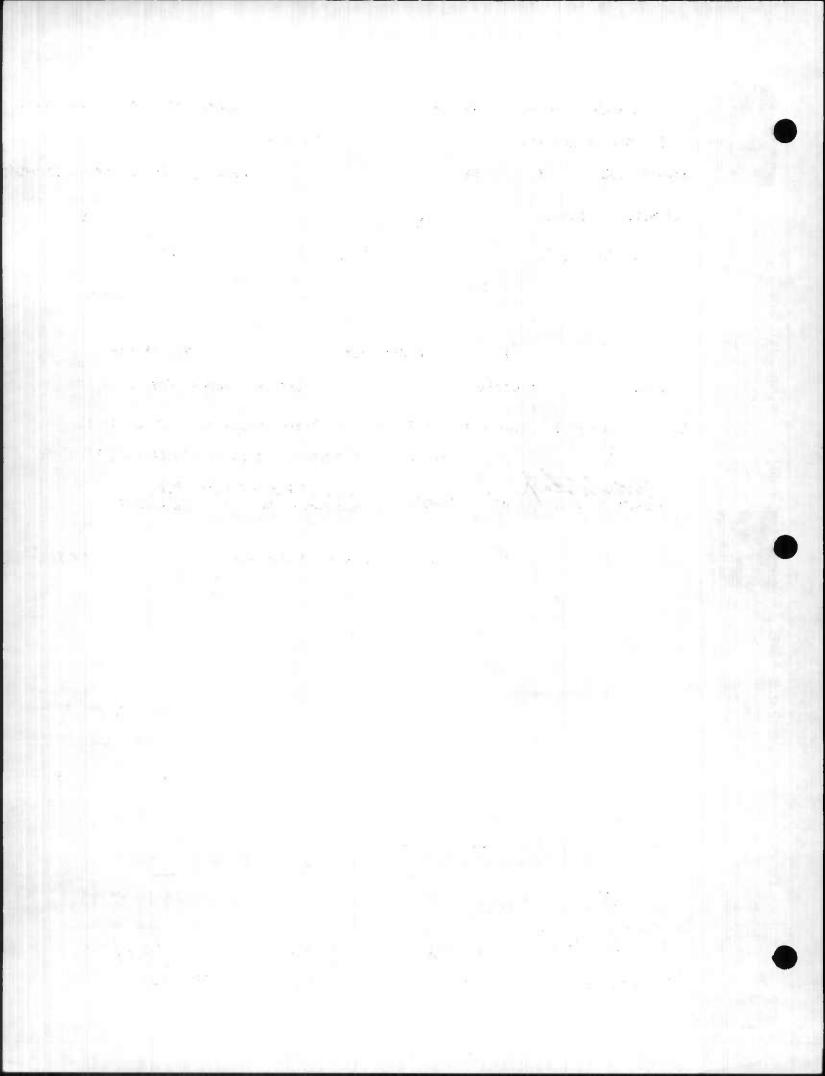
State Registrar

JAN 2 6 1999

32. Registrer's Signeture

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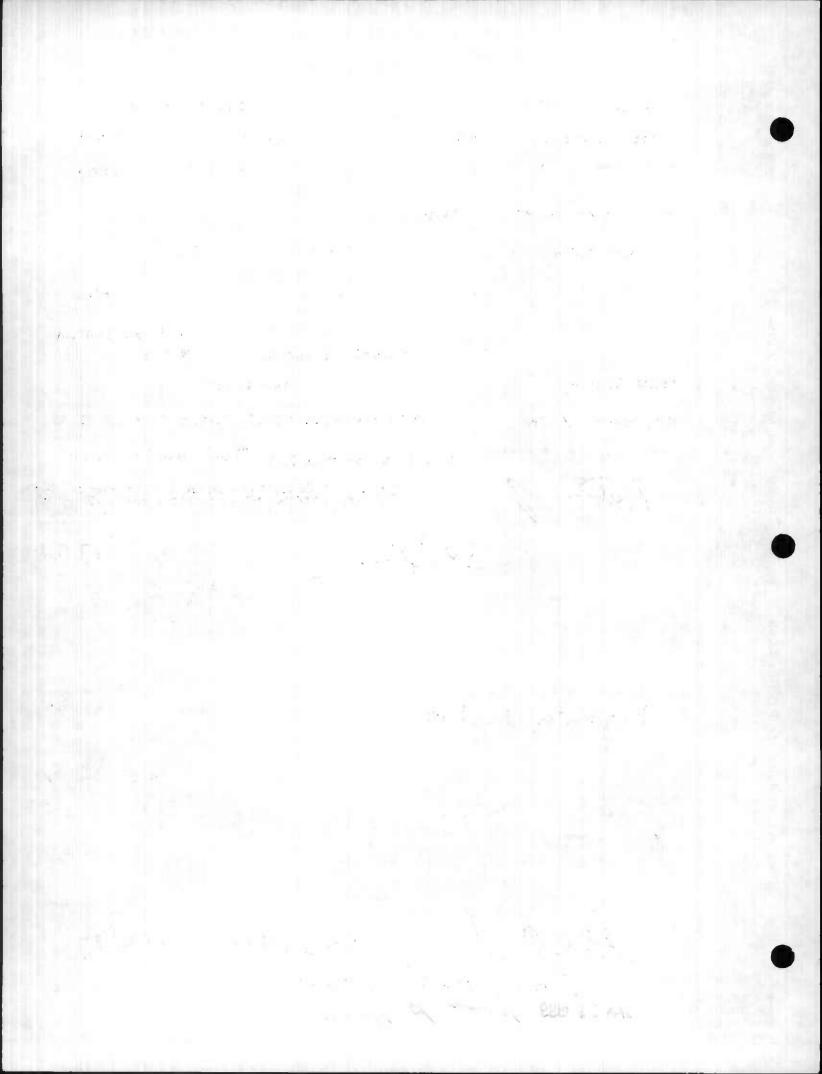


State of Maryland / Department of Health and Mental Hygiene Amend. 20a 1/19/99 SM AACO Health Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Physician 6:04 pm Joseph Torchia January 14, 1999 /Medical 4e Facility Neme (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State (Month, Day Year) Country)
April 10, 1918 Maryland If Under 1 Yeer 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 215-05-0546 **Funeral** Days Months Hours 1X M 2 □ F 80 Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, me Modical Examinar must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 249 Cypress Creek Road 21146 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 14. Rece - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or then any injury or other traumatic event, the medical Exemi 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Security College (1-4or 5+) 5+ Elementary/Secondary (0-12) Agency Personnel Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Torchia Erma Dourre 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 249 Cypress Creek Road, Severna Park, MD 21146 Mary Torchia / wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Jan 18 20c. Location - City or Town, State -1 Xourial 2 Cremetion 3 Removel from State Glen Burnie, MD 4 Donetion 5 Dother (Specify) entombmentGlen Haven Memorial Park 1999 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finat disease or condition resulting in death) Examiner Examiner the ettending physician end hed for use as the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Due to (or as a consequence of): Box 68760 certificate be Physician/Medical Due to (or es a consequence of): 98 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Othor significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. deteched 2 1 Yes 2 No 3 Probably 4 Baknown Division of Vital Records, þ 90 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to Completed peen completion of ceuse of deeth? has page 2 2000 1 Yes 2 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 → Coatient 2 □ ER/Outpatlent 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this 28a. Date of Injury (Month, Day 27. Menner of Death uneral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation death. 1 ∏Yes 2 ∏No I or Attendi efter death Director: A d in by the f 2 Accident 6 Coutd not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde To the Hospital within 24 hours of To the Funeral Completely filled Hospital Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tig 29c. License number 30. Name end eddress of person you completed ceuse of deeth (Item 23e) Type, Print) Franklin & Cathedral St. Steven C. Resnick, MD 31. Date filed (Month, Day, Year) JAN 19 1999 Annapolis, MD 21401

32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 21,1999 MARY MADELINE TYLER 4b. City, Town, or Location of Death 4c. County of Death 0821 /Medical 4a Facility Name (If not institution, give street end number) Examiner WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Dec. 25 1914 Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. lest birthday) **Funeral** 1□M 2|2F 220-03-9772 Maryland **Director** Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No r than "natural", or itema 23a or 28a-f a the Medical Examiner must be notified Directo MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2339 Hudson Rd. # 202 21613 Funeral 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: λq Specify: white 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) state hospital attendant 18. Mother's Name (First, Middle, Maidan Sumame) 17. Father's Name (First, Middle, Last) should be fund Mental 9 marked of George Riley Andrews Marjorie Helen Andrews 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. tnformant's Name/Ralationship (Type, Print) 214 East Appleby Ave., Cambridge MD 21613 if Health Item 27 i Leon M. Peters - son 20b. Place of Disposition (Neme of cematary, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State Dorchester Memorial Park 1-23-99 Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses 22. Nama and Address of Facility Thomas Funeral Home PA nemettsk 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the diseasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** Low Cardine out put - Sever me had reguegetation & Horhistener /Medical tmmediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner Complete Heart block 112 death certificete be executed -annulas attending physicien end for use es the bunal-trans Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Mitral & Callet cateou Physician/Medicai Dua to (or as a consequence of): resulting In death) Last 50 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4€Unknown 3 by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy parlomed? Completed certificate hes 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminar? Be 26. Place of Daath (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 this 27. Manner of Death 28c. injury at Work? 28d. Dascribe how injury occurred Certification: or Attending P effer death. Director: After Affer 1X Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Plece of Injury - At home, farm, street, fectory, offica building, atc. (Specify) 4 | Homicida 24 hours e Funeral D 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and mannar as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. (Check only one) To the P within 2 To the P 29d. Date signed (Month, Day, Year) 29b. Signature and title of certiled 29c. Licanse number 14/81 30. Name and address of person who completed edusa of death (Item 23a) (Typa, Print) AGANHAL, SALISBULY MD SHOTE OT. M.O. 614 C. EASTERN

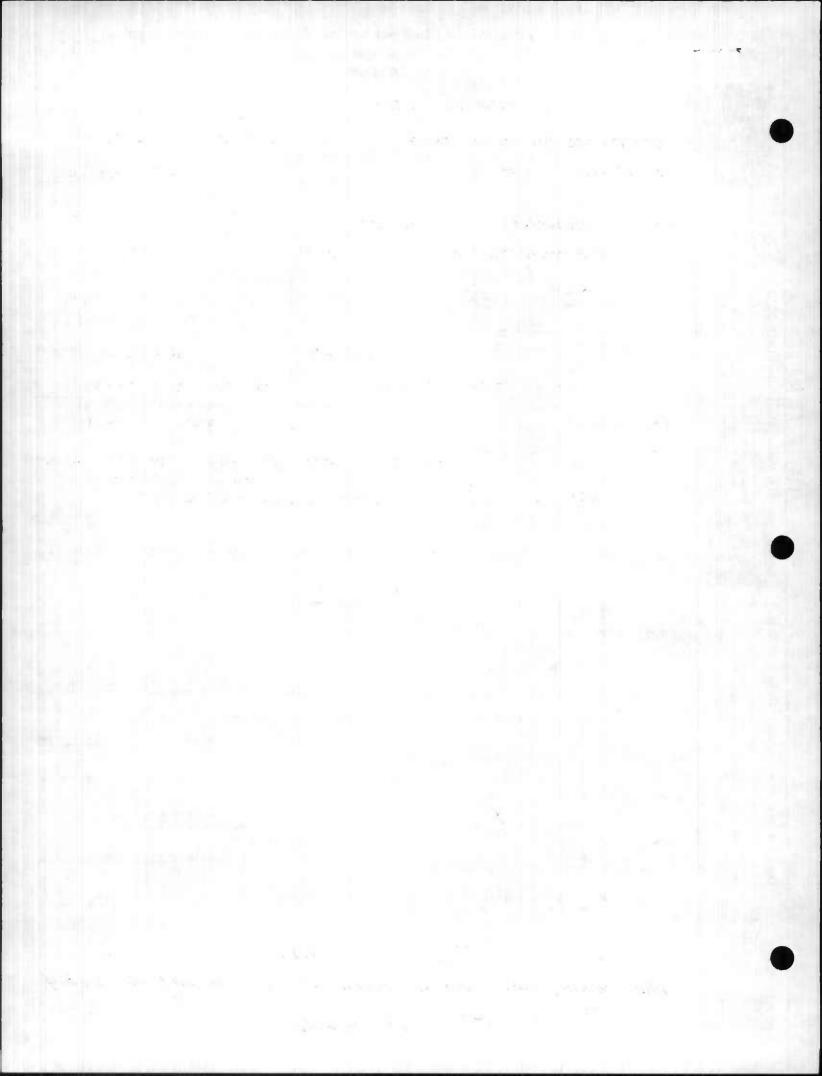
Registra

State

31. Data filed (Month, Dav. Year)

JAN 2 2 1999

32. Registrar's Signatura



Division of Vital Records. P.O. Box 68760.

or Attending Physician: death.

n 24 hours after death.

• Funeral Director: A pletely filled in by the fu Hospital To the To the Comple



Registrar

Certifying Phyeician: To the best of my knowledge, death occurred at tha tima, data and place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, end due to the causa(s) and manner stated. 29c. License number D 47066

29d. Dete signed (Month, Day, Year) 1-18-99

30. Nama end eddress of person who complated ceuse of deeth (Item 23e) (Type, Print)

A.D. Shah, MD

29b. Signature and title of certifier

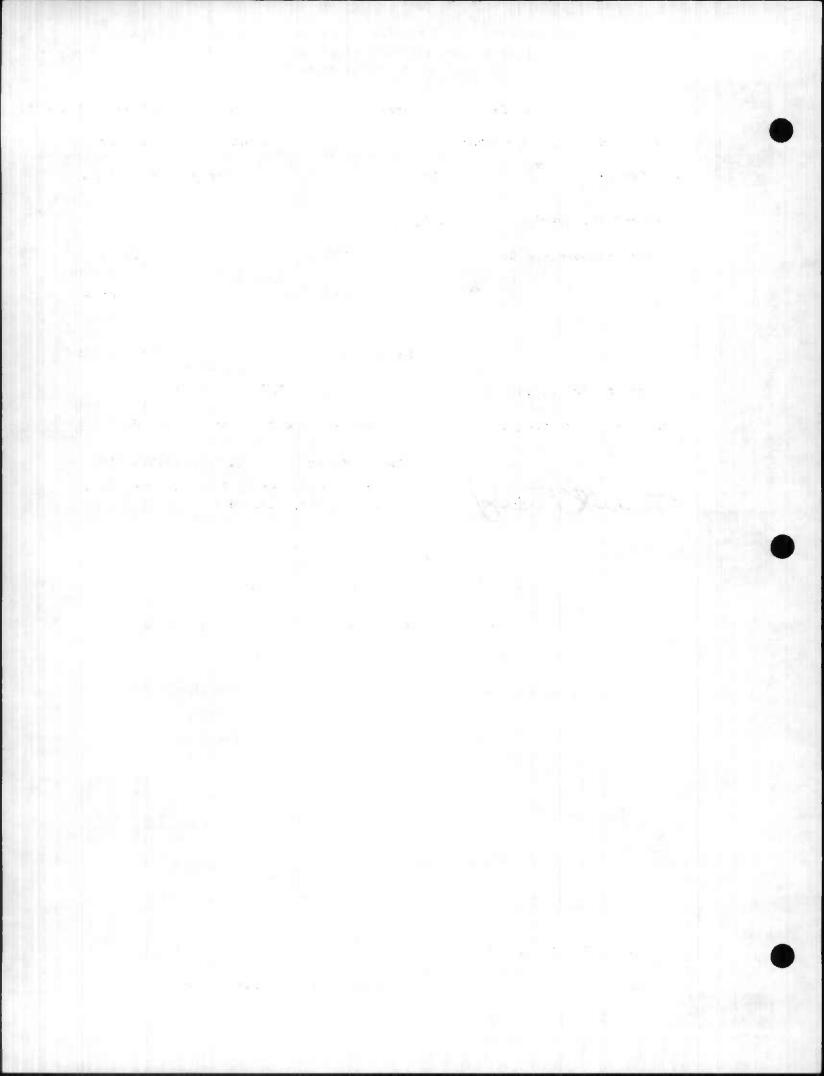
29a. Cartifiar (Check only one)

Leonardtown, Maryland 20650

31. Date filed (Month, Day, Year) JAN 1 9 1999







State of Maryland / Department of Health and Mental Hygiene Q Q

Certificate of Death 2. Date of Deeth 3. Time of Death Month 6:20 PM January 18, 1999 Franklin Tippett Sr. 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death 24510 Pincushion Road St. Mary's Leonardtown If Undar 1 Yaar | If Undar 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) ₩ 2DF Months Days Hours 87 Yrs. October 17, 1911 Maryland 10c. City, Town or Location 10d. Inside City Limits St. Mary's 1 Yes 2 No Leonardtown 10f. Zip Code 10g. Citizen of What Country?

White

Approximate Interval Between Onset and Death

completion of cause of deeth?

1 ☐ Yes 2 ☐ No

Funeral Director

Physician

/Medical

Examiner

1. Decedent's Neme (First, Middle, Last)

5. Sociel Sacurity Number

10a State

Director

Funeral

by

leted

Comp

Be

Maryland

10e. Street and Number

220-34-8071

Usual Rasidence of Deceden

Robert

10b. County

with the Maryland

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at permit. Pages 1 and 2 should be filed within 72 hours after death vacaper transity of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examples 2008.

Maryland 21215-0020

Baltimore,

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

requires that the death certificate be axecuted ician and buriel-trans Box 68760. physician the 98 980 the 3 Division of Vital Records. 8 has Attending Physician: funeral director, this After I or Attending after death. Director: Aft 24 hours Hospital completely within 2 To the

20650 24510 Pincushion Road U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorcad 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Farm Farmer 8th 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Wilber Francis Tippett Mary L. Long 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 24510 Pincushion Road, Leonardtown, MD 20650 Elizabeth Rose Tippett/Wife 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 20a. Mathod of Disposition 1X Burlal 2 ☐ Cremation 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify) 1/20/99 Trinity Memorial Gardens Waldorf, MD 21. Signature of Funeral Service Licens 22. Name and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. Jardener P.O.Box 270, Leonardtown, MD 20650 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line. istice Herr Falue Immediate Cause (Final disaasa or condition resulting in deeth) Due for es a consequence of Sequentielly list conditions, if any, leading to immediate cause. Enter Undartying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown mee 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to

1 Inpatient 2 ER/Outpetient 3 DOA

28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28b. Time of

Registrar

David M. Federle, MD 31. Date filed (Month, Dey, Year) JAN 2 0 1999

290 Signature and little of certifie

25. Was case referred to medical examiner?

5 Pending

invastigation

6 Could not be

1 Yes 2 No

27. Menner of Deeth

1 ANatural

2 Accident

4 | Homicide

3 Suicide

(Check onl)

29a. Certifier

32. Registrer's Signeture

Hospitel:

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

28a. Date of tnjury (Month, Dey Year)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the cause(s) and manner es stated.
2 Medical Examiner: So the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

Hollywood, MD 20636

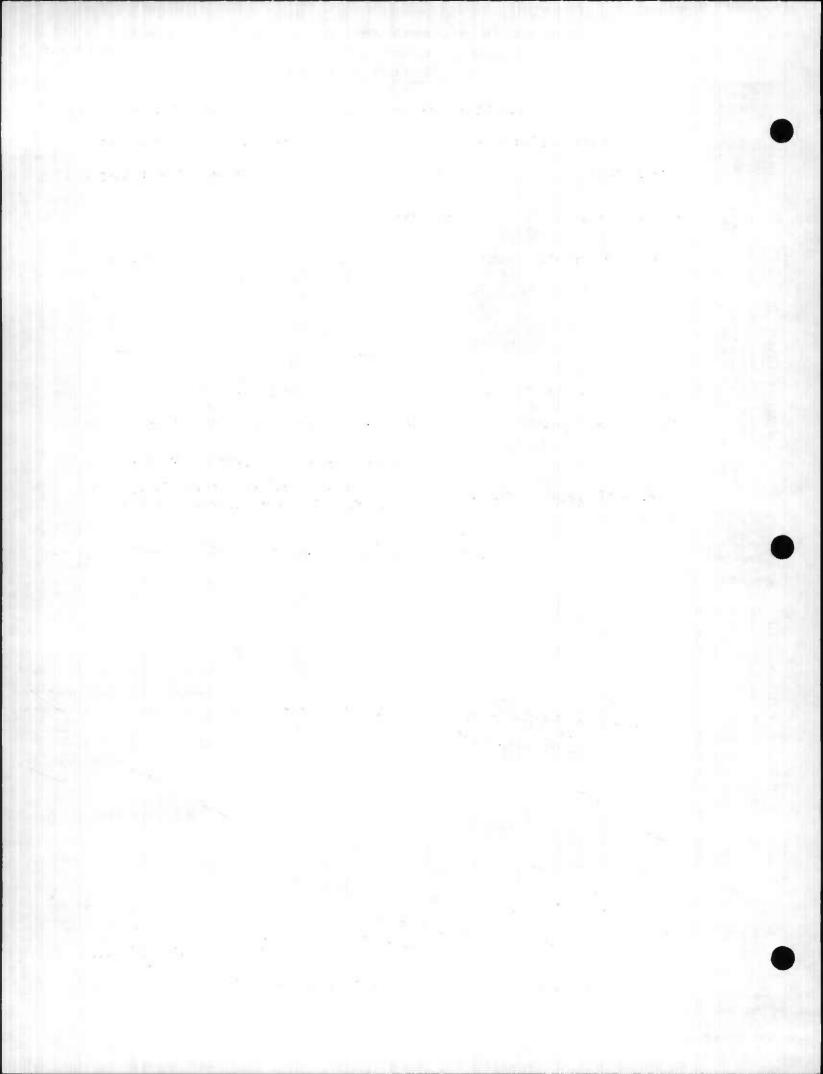
26. Plece of Death (Check only one

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

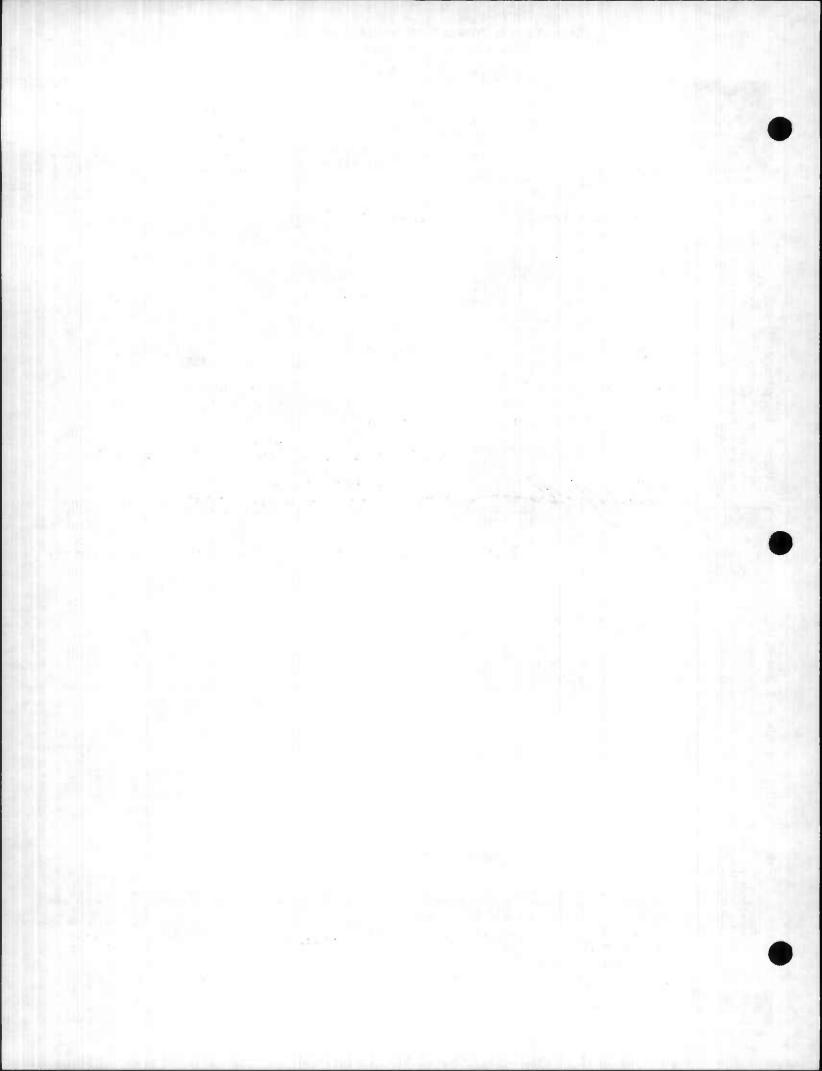


State of Maryland / Department of Health and Mental Hygiene 9 9

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sician edical	W.	Beatr	rice	Maı	rie	VanB	oven					Janua	ry 2	22,1		5:	30am
miner	4a	Facility Name (#	not institution	, give st	treet and nu	um <i>ber</i>)				4b. City, To	wn, or Lo	ocation of Deat	h 4c.	. County			
		2 Pros	spect	AVE	enue					indi	an	Head,		Ch	arle	S	
ral	5. 5	Sociel Security Nu	mber	8. Sex	_X	7. Age (In)	rs. last birth	day) If Und	der 1 Year		24 Hrs. Min.	8. Date of Bir (Month, Da	rth)	9. Birthpl	ace (Ste	te or Foreig
or	2	12-22-468	84	10	м श्रामे	74	Y	rs.	s Days	Hours		ctober	12,	1924	Mar	yla.	nd
-		ual Residence of I															
vieted by Funeral Director	108	a. State	10b. County			10c.	City, Town	or Location							10		e City Limits
to	Ma	aryland	Charle	es			Indian	Head								189	res 2 No
9	10e	e. Street and Num	ber					10f. 2	Zip Code				10g. Cit	itizen of W	Vhet Coun	try?	
10	#2	2 Prospec	ct Ave						2064	0			U.	S.A.			
Funeral Director	11.	Marital Status		13	2. Was Dec	cedent Ever I	n U,S.	13. Wes Dec	cedent of I	Hispanic Ori	gin? (Sp	ecity Yes or No	0-		- America		١,
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Completed			15. Decedent	's Educe	etion		16a. I	Decedent's Us	sual Occu	pation			16b. K	(Ind of Bu	siness/ind	lustry	
pie		(Specification) Elementary/Secon	fy only highes	t grade) (1-4or 5+)	- (Decedent's Us 'Give kind of the life. DO NOT	work done use retire	during mos	t of work	ing					
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BeC	17.	Father's Name (F	First, Middle, I	Last)						18. Mothe	er's Name	e (First, Middle	, Maiden	n Sumame	Θ)		
To B	Jo	oseph Hei	nry Bos	swe]	1					Res	ssie	Johnso	n				
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		obert Lo						same as									
	-	a. Method of Dispo		IIDO V	CII	20	h Place of I	Disposition (A	Veme of			Dete	20c. Le	ocation -	City or To	wn, Stat	9
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Registrar



State of Maryland / Department of Health and Mental Hygiene 9 028 18

						Cen	tificat	e of	Death		R	g. No.		() I	
			1. Decedent's Name (First, Middle, Last,	1		- 3					2. Date of Deat	h		3. Time of	Death
	Physicia: /Medica	-	Helen Lucille	Williams							Month Jan.	Day 17	1999	8:38	PM
	Examine		4a Facility Name (If not Institution, give	street end number)					4b. City, To	own, or Lo	cation of Death	4c. Cou	nty of Deeth		
		H	Genesis Eldercar	e - Spa C	reek Ce	nter			Anna	apoli	s	Anı	ne Aru	ndel	
	Funeral		5. Social Security Number 6. Security 17-28-8707	7. Age	(In yrs. last bir	rthday) Yrs.	If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey,	Year)	9. Birtha	place (State or	Foreign
	Director	-	Usual Residence of Decedent		07		-				July 11	, 191	I Ma	ryland	
	show		10a. Stete 10b. County		10c. City, Tow								1	0d. Inside Cit	
	The same	Director	Md. Anne Aru	ndel	Ann	apo l	7								
	or Nerns 23a or 28s-f show or Nerns 23a or 28s-f show or near must be notified at		10e. Street and Number 901 Cedar Park	Road			10f. Zip		21401		1		of What Cour	ntry?	
		Funeral	11. Meritel Stetus	12. Was Decedent E Armed Forces?	ver in U,S.	13. W	Vas Dece	dent of h	lispanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)		lace - Americ		
020		Dy ru	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗓 N if Yes, Give Year or Dates:	0		☐ Yes				riicari, etc.)	Spe			
21215-0020	n /z hours natural', edical Exu	Deg	15. Decedent's Edu (Specify only highest gred	cation completed)	16a	Decede	ent'a Usu	al Occup	pation during mos	st of worki	ina	16b. Kind of	Business/In	dustry	
121		Completed	Elementery/Secondary (0-12)	College (1-4or 5-	+)		omem		during mos d)			Ora	n home		
d 2	Hygie other	3	17. Father's Name (First, Middle, Last)			110	Omem	aker		ar's Name	(First, Middle, M				
5	Mental Mental	a	Charles W. Jones								Wells	naiden Sun	alliej		
2	ind Menta	9	19a. Informant's Name/Relationship (Ty	no Grieti	106	Mailine	a Addrag	/Ctroot		_	NETIS Il Route Number	City or To	on Chata Zia	Codel	
Ma	T is mu		Sarah Moreland / d				ewey				polis, N		1401	C009)	
ď.	Health am 27 other tr	-	20a. Method of Disposition	augnter	20b. Place o				ve	Aillia			n - City or To	own State	
Baltimore,	200		1 ☑ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	emovel from State	Cedar	ry, crem	atory or o	other ple		1-			lis,		
Balt	Department of important: If any injury or once.		21. Signature of Funeral Service License	» D	00	22.	Name ar	nd Addre	ess of Facili	y Joh	n M. Tay	lor I	unera	1 Home	,Inc.
		4	L- Dran	Powe	ll						ter St.		olis,	Md, 2	1401
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ox 68760,	physician and s the burial-transit	X	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or as a	obligado	ience of):	7					ŧ		
68760,	sicia bur	20	Cause (Disease or Injury that initiated events) to for on a								-		
89	ng phy as the	8	resulting in death) Last	L	Oue to (or as a d	consequ	ience or):						t		
Вох	use a	2		l									1		
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	ned by the attendir	Physiciany	Part II. Other aignificant conditions con	tributing to death bu	t not resulting ii	n the un	oenying o	ause gr	ven in Part	1.	100	eaccoule			Inknown
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	been signed t	Completed by						1			24a. Was a perform		av	ere autopsy fi ailable prior to impletion of ca death?	
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5	is after deeth.		4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, fa (Specify)	ırm, stre	et, factor	y, office			28f. Location (St City or Town		mber or Run	al Route Numi	ber,
To the Hospital	within 24 hours after death. To the Funeral Director: After this cardific completely filled in by the funeral director.		29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	er: On the basis of a	examination an	, death d/or inve	occurred estigation	at the ti	me, date ar opinion, dea	nd place, ath occurr	end due to the ca	use(s) and ate and pted	manner as a	tated. the cause(s)	
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1	8 = 8		· CAM	MD			3		895	8		1/2	1.		
			30. Name and address of person who co		ath (Item 23a)	(Type, P	Print)	2	1			-/-			- 12
			Datiet Sinol	Sichh	1413	A	nnul	oh	L R	oad	#106	ode	nton	MD 21	113
	State Registrar		JAN 2 1 1999	39. Registra	r's Signature		1								

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🍳 🤉 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 2:00 RM Mary Mildred Walker 13 Jan. 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6 1-2 Constitution Avenue Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 25 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 F 1909 Days Hours Months Mary land 89 Aug. Yrs. 217-52-4381 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2□ No Maryland Anne Arundel Annapolis 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 1-2 Constitution Avenue 21401 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: white 1 Yes 2 No Specify: 3 Widowed 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Homemaker own home 17. Fether'a Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Wilbur P. Donaldson Mary E. Mayhew 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Richard W. Walker (son) 4 Oak Court Annapolis, MD 21401 20b. Place of Disposition (Name of completely, crematory or other place)
St. Warys Cemetery 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Burlat 2 ☐ Cremation 3 ☐ Removal from State 1-18-99 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Servica | Conson 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cevebrovascular disease YVS. Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or es a consequence of): Due to (or as a consequenca of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 - Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Physician:

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Physician

/Medical

Examiner

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f ahow any brighty or other traumatic avent, the Modical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Examin physician end the buriel-transit Physician/Medical 88 esn Po ed by the a signed t þ Completed page 2 s certificate has Be Certification: To this After death. after death Director:

26. Piece of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Z Naturel

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be determined 28e. Pteca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. tnjury at Work? 28b. Time of 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29e. Certifier (Check only one)

2 ☐ Accident

3 Sulcide

4 Homicide

1 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

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29c. License number

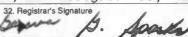
29d. Date signed (Month, Dav. Year) 14 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart E. Selonick, MD, 900 Bestgate Rd., Annapolis, Maryland 21401

State Registra

31. Date filed (Month, Day, Year) JAN 1 9 1999



TOTAL BANKS

State of Maryland / Department of Health and Mental Hygiene () () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:00 Pm 1999 Annie Ruth Whitacre dan 11 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Goodwill Mennonite Home Grantsville Garrett H Under 1 Year if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 XF 101 Yrs. Director 236-68-2542 Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it is leaded to the present and it is not other traumatic event, it is leaded to the present of the present o Garrett Grantsville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 891 Dorsey Hotel Road 21536 USA Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 □ Never Merried 2 □ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) Coilege (1-4or 5+) Minister Church Ministry 4 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) J.C. Beahm Emma Shocklev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel J. Whitacre/son 118 Chipmunk Lane, Meyersdale, PA 20b. Piece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Country Side Crem. Jan 12,1999 Davidsville, PA 22. Name and Address of Facility
Newman Funeral Home, Inc., P.O. Box 116 21. Signature of Fuperal Service Licansee & Luce Salisbury, PA 15558 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervei Between Onset and Death **Physician** STROKE /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of) buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest and Due to (or as a consequence of) physician a Box 68760. Physician/Medical Due to (or as a consequence of) 950 P.O. been signed by the a should be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ #4b. Were eutopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? page 2 certificata 1 Yes 2 MNo 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifice Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Other: 4 Aursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 TNo 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) plataly filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and little of cartifier 29c. License number 29d. Date signed (Month, Dev. Year)

Frantsville

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State Registrar 30. Name and address of person who completed cause of geeth (Item 23e) (Type, Print)

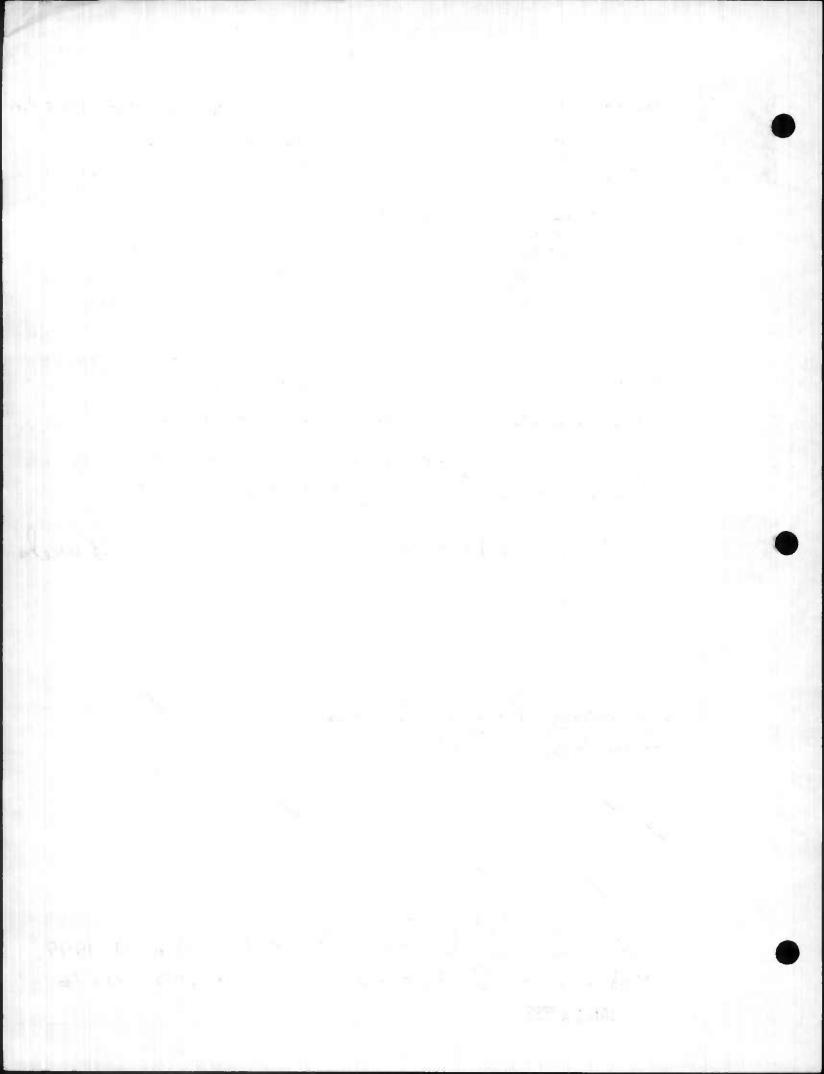
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31. Date filed (Month, Day, Year)

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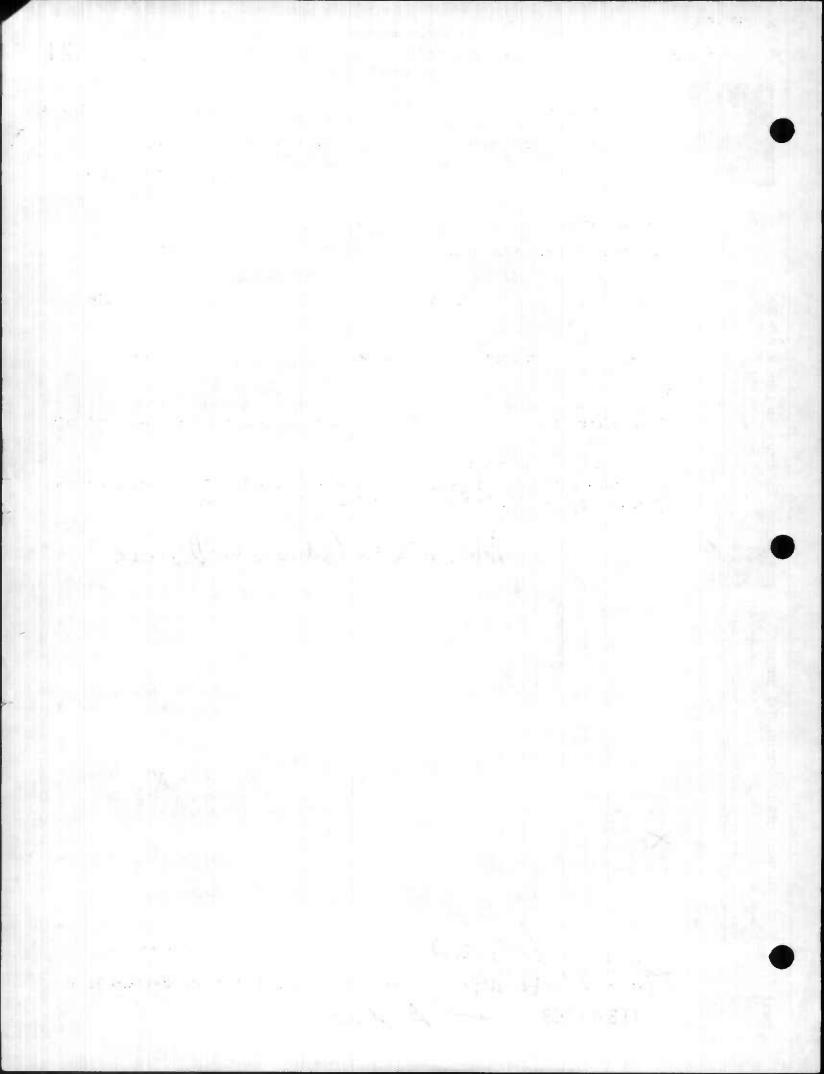
32. Registrar's Signature



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State Registrar

31. Date filed (Month, Day, Year) FEB 0 4 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Hrnold 5 in /Medical 4e. Facility Name (If not institution, give street and number) 700) w. 46th St. 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Keswick Mutti Care Center Baltimore If Under 1 Year If Under 24 Hrs.

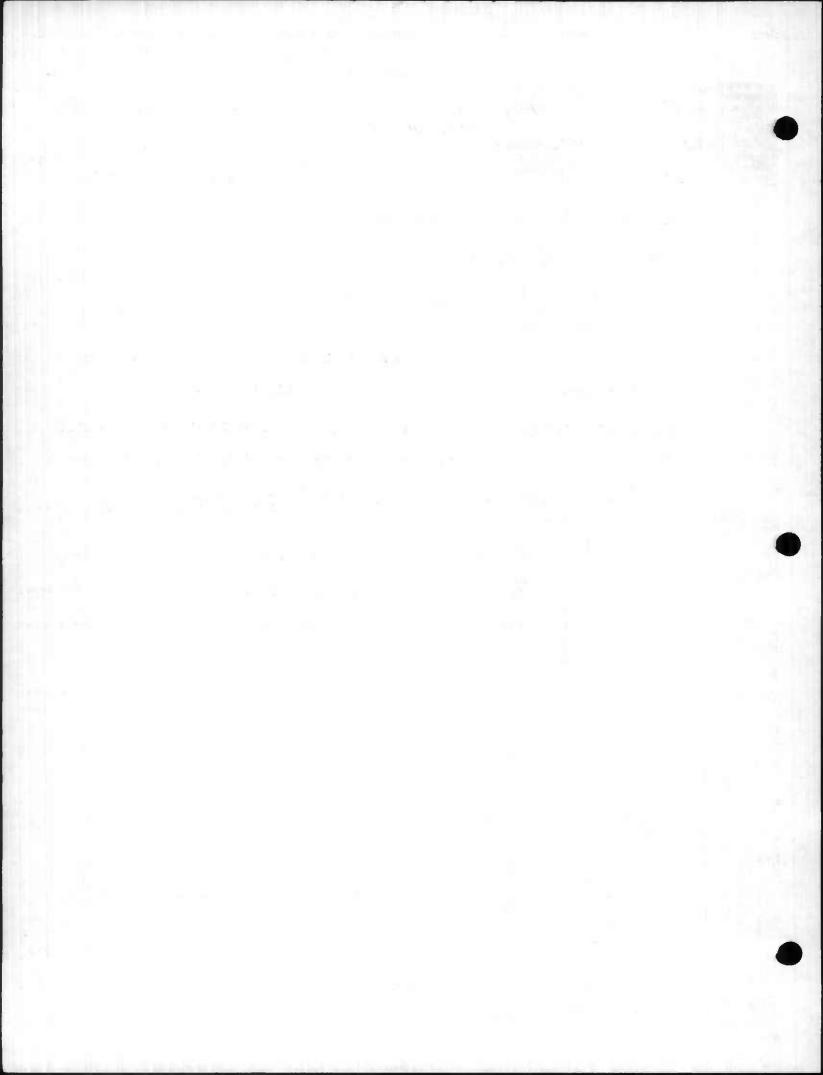
Months Days Hours Min, 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1∭M 2□ F Yrs Director 214-14-2165 Dec 8, 1917 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryla Department of Heelith end Mental Hyglens. Important: If flem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, in Mandae Examinar main be notified any Injury or other traumatic event, in Mandae Examinar main be notified. Director 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? (Apt 1004) 21211 U.S.A Funeral 3838 Roland Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 1√ Yes 2 □ No If Yes, Give WW II Year or Detes: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0020 þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Cotlege (1-4or 5+) 9 Assemble Line General Motors 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Walter Arnold Lillian Stump 19a. intormant'a Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3838 Roland Avenue (Apt 1004), Balto, Md 21211

20b. Place of Disposition (Name of cometery, crematory or other place)

Date

20c. Location - City or Town, State Esta Arnold 20a. Method of Disposition (Wife) 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stete
4 ☐ Donation 5 ☐ Other (Specify) Greenmount UMC Cemetery 2/4/99 Hampstead, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility llan A. Alan Seitz, Jr. Funeral Home 3818 Roland avenue, Baltimore, Maryland 21211
23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760. witery duse Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy tindings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? page 2 s 1 Tyes 2 No 1 Yes 2 No or Attending Physicien: funeral director, 25. Was cese reterred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: 1 ☐ inpatient 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Day Year) 27. Mann of Deeth 28c. injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Maturat within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) in by 4 - Homicide completely filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause ot deeth (Item 23a) (Type, Print) 700 W. 40 & STREET, BALTIOTORE, 07021211 KESWICK REGOR 31. Date filed (Month, Dey, Year) FEB 0 4 1999 32. Registrer's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Tima of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) February 03 Month **Physician** Hldrich Bea PM irainia /Medical 4b. City, Town, or Location of Death Facility Name (If not Institution, give street and number) Continuum Care at
Social Security Number 6. Sex Examiner 5 Kes Ville SykesVIIIe

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. May 28, 19 Birthplaca (State or Foreign Country) Funeral 1 M 2 F 492-28-5050 Usual Residence of Decedent Missouri Director the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examinar must be notified at 1 Yas 2 No Director Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7309 2nd Avenue 21784 United States permit. Peges 1 end 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a any hijury or other treumatic event, the Medical Examinet mast. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 No it Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, etc. 1 □ Naver Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: py 3€ Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Manager/Customer Service Retail 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Virgil F. Poncin Beatrice B. Scrogham 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Victoria Pizzillo/Daughter 18860 North 78th Lane Glendale AZ 85308 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel trom State 2/8/99 4 ☐ Donation 5 ☐ Other (Specify) Ellicott City, MD Good Shepherd Cemetery 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the deeln. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or heart failure. List only one cause on each line. **Physician** Atherosterotic Coronery Vind Direct Immediate Cause (Final disease or condition rasulting in daath) /Medical **Examiner** Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence ot): 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the 1 Yee 2 No 3 Probably 4 Unknown λq 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peed 1 ☐ Yas 2 No 1 Yas 2 No 25. Was cese refarred to medical 26. Piece of Death (Check only one)

certificata Hospital or Attending Physician: director, this

Be 10 funeral Certification:

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Sulcida

29a. Certifier

4 Homicide

(Check only one)

31. Date tiled (Morith, Day, Meer)

after death.

24 hours a To the Hosp within 24 hor To the Fune completely fi

State Registrar

Medical

29b. Signeture end title of certifier Rock J. Man, us

5 Pending

Investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, tarm, straet, factory, office building, etc. (Specify)

28b. Time of

29c. License number 8m 2582420

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

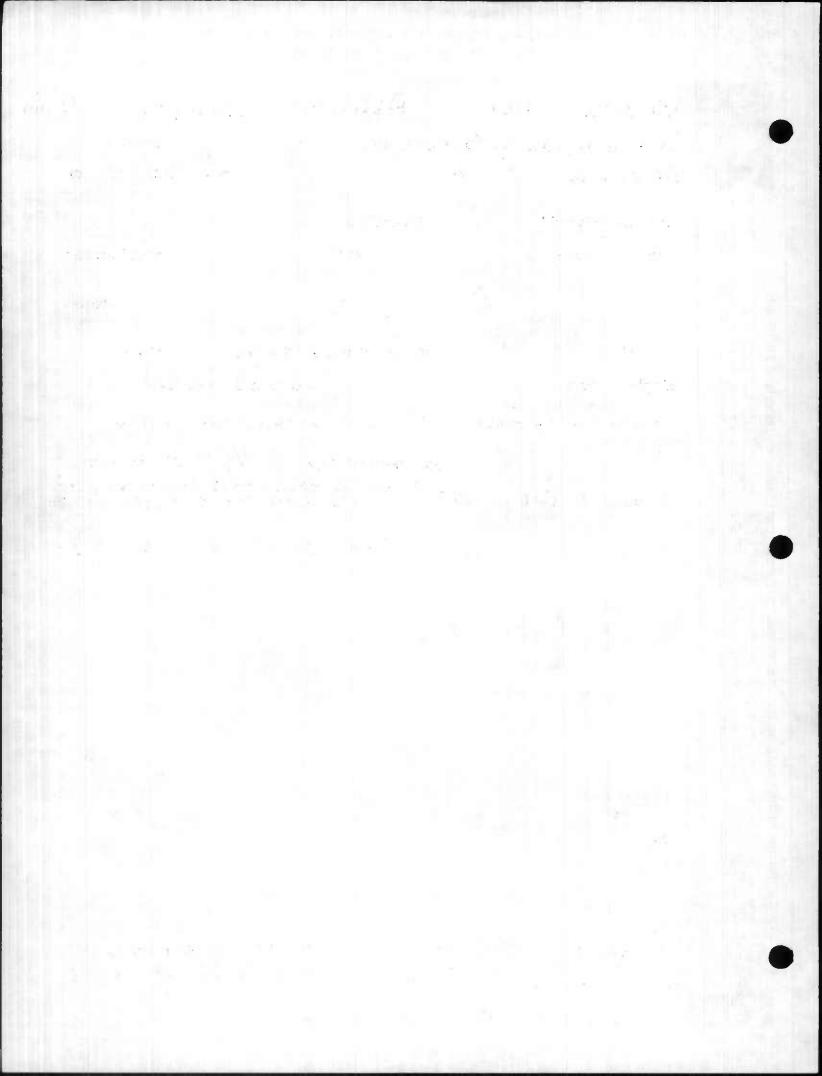
Other: 450 Nursing Home 5 - Residence 6 Other (Specify)

28d. Describe how injury occurred

February 4, 1999 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)
Robert L. Moss 114 Basiners Cent- O. Reiston, for, Ml. 21136

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ralph Edwin Barkdoll January 21, 1999 8:15 P.M /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys Hours 1 M 2□ F Yrs. 171-30-7178 **Director** March 16, 1936 unknown Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show advert Example in must be notified at 1 ☐ Yes 2 ☐ No Maryland Frederick Thurmont Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code P.O. Box 51 21788 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces? unknown
1 □ Yes 2 □ No
If Yes, Give
Yeer or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status parmit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiena. In mortant: If Nem 27 is marked other than "natural," or flen any injury or other traumatic event, the Head of Pages. 1 5t Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 18. Mother'a Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown P 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) unknown 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State 4 □ Donation 5 ② Other (Specify) in state 21. Signeture of Funeral Servica Licensee Ronald S. Wade ²² Name end Address of Facility State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 rd. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PULMONAUE HANDIN O) Examiner Due to (or es e consequence of) Physician/Medical Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequenca of): 23b. Did tobacco was contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner stated. 29a. Certifier Medical

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 for use as ed by the a signed by to been si cartificata or Attending Physician: this After death. after death Director: • Funeral Di Hospital within 2 To the the

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Baltimore, Maryland 21215-0020

State Registrar

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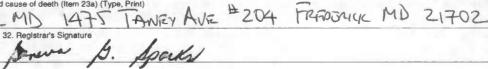
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30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

(Check only one)

29b. Signeture and title of certifie

31. Date filed (Month, Day, Year)



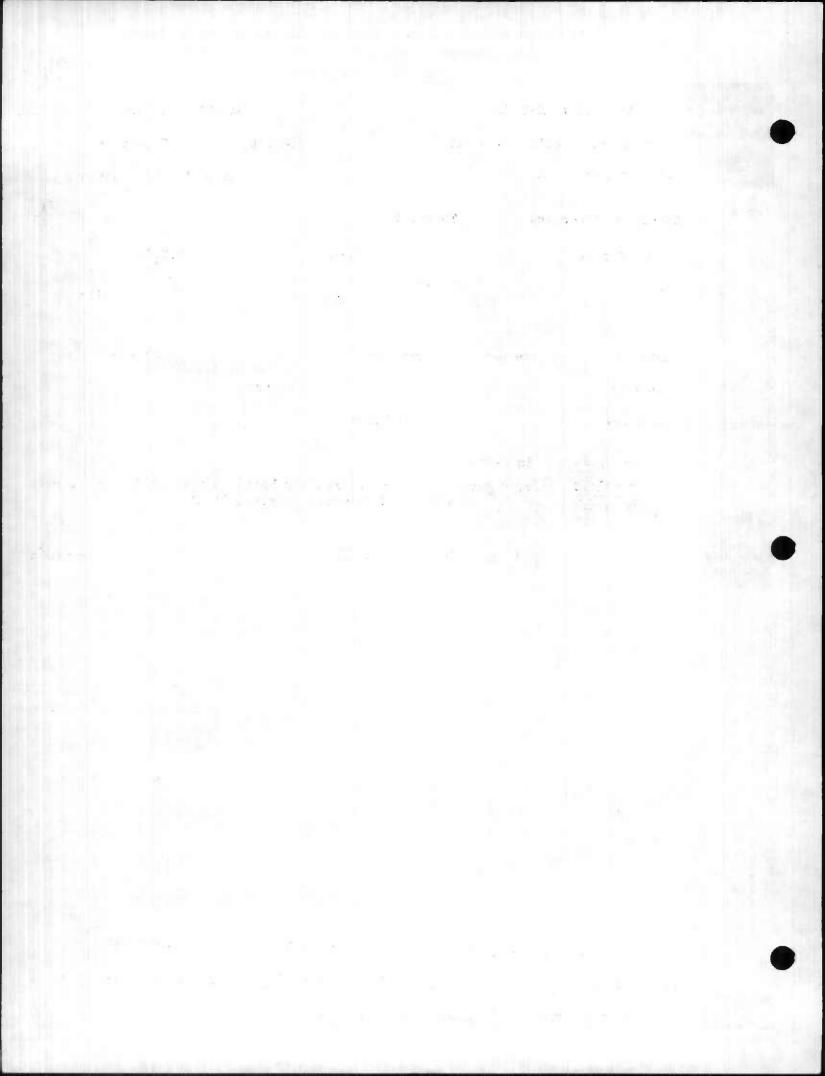
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29c. License number

17974

29d. Date signed (Month, Day, Year)

1-23-99



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 02825 Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Day 2 9 tebl 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) More Birthplaca (Stata or Foraign 8. Date of Birth (Month, Day, 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last irthday) 218-48-2975 Usual Rasidance of Decedant Months Days Hours Min 1 M 2 KF Yrs. 449.2 10b. County 10c, City, Town or Location 10d. Insida City Limits 1 Vas 2 No Maryland mor 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? d 12. Was Decedant Evar In U.S. Armed Forces? 1 Yas 2 No If Yas, Gival Yaar or Datas: Was Dacadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Navar Married 2 ☐ Married 1□ Yas 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 9 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT use retired) (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) me (First, Middla, Maidan Sumame) 18. Mother's N SOY 19b. Mailing Addrass (Street and Number of Rural Routa Number, City or Town, Stata, Zip Goda) 9 0 01 20b. Place of Disposition (Nama of cematary cramatory or other p 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Nationa re of Funeral Service Dicense 22. Nama and Addrass of Facility Joseph er al or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximata Intarval Batwean Onset and Death Immediata Causa (Final disaase or condition rasulting in daath) Due to (or as a consequence of) Dua to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 32 No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death

Physician /Medical Examiner physician and

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be

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or Attending Physician:

To the

death.

Director:

within 24 hours a To the Funeral D completaly filled Hospital

filled in by

by

Completed

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Certification: To

edicai

Physician

/Medical

Examiner

10a. State

Funeral Director

by

Completed

Be

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Hauth and Mental Hydiana.
Important: if item 27 is marked other than "natural properties of the second properties."

Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last been signed by should be detac

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to me examiner?

28c. Injury at Work?

1 Yes

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifian

Natural

2 Accidant

3 Sulcida

4 Homicida

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c/Licansa number

29b. Signatura and titla of cartifiag

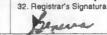
5 Panding investigation

6 Could not be determined

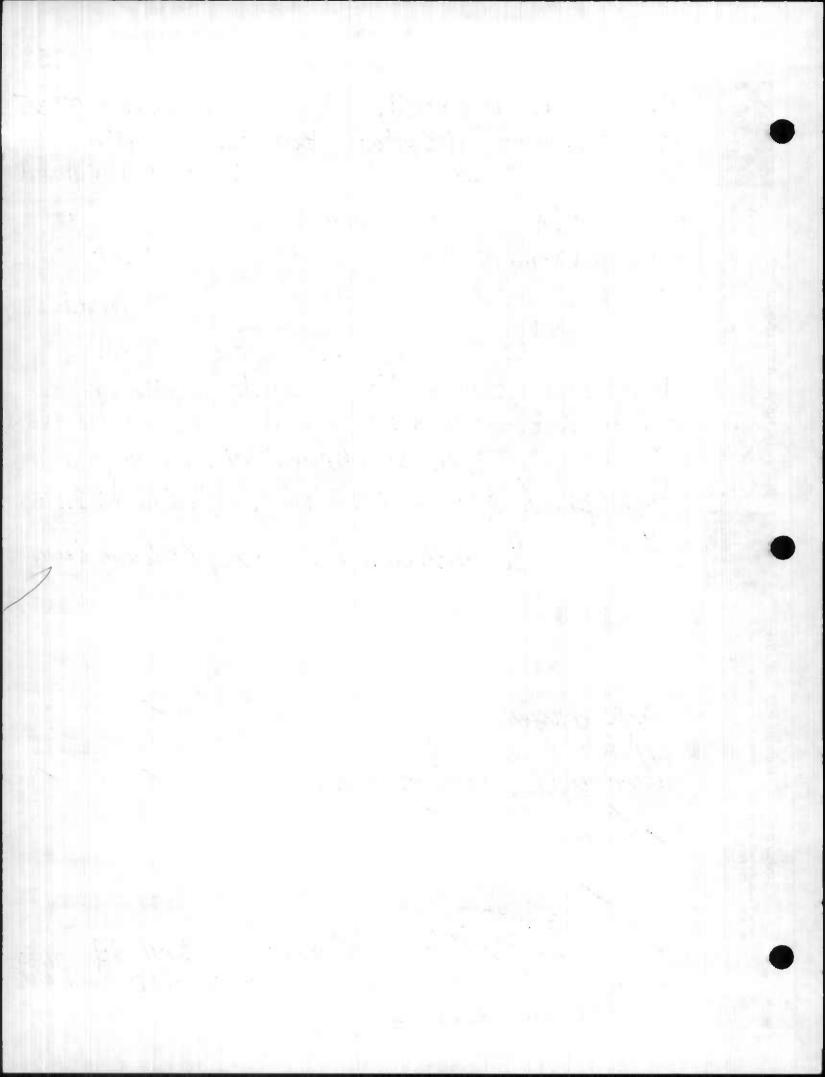
29d. Data signad (Month, Dav. Year)

dausa of death (Item 23a) (Type, Print) 30. Nama and addrass of person

State Registrar 31. Data filed (Month, Day, Year) FEB 4 1999



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Items: 16a, b, 17, 18, 20b, c State of Maryland Department of Health and Mental Hygiene 9 Item: 26 per M.D G-768 2/4/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 7:18 a.m. 1999 Euthella Feb. 1, /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice Center Owings Mills **Baltimore** If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthpiace (State or Foreign Country) 5. Social Sacurity Number 6 Sax 8. Data of Birth (Month, Day, Year)
Oct - 13,1911 7. Age (In vrs. last birthday) **Funeral** Days 1 M XXX Months 87 Director 242-64-2368 NC Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10h County 1 Yes 2 No Director MD Baltimore Turners Station 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Oak St. 21222 USA Funeral 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yas ②□00 If Yes, Giva Yaar or Dates: Was Dacedent of Hispanic Origin? (Spacify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarlcan Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other treumstic svent, the Model Example 2008. Biack, White, etc. 1 ☐ Never Married 2 ☐ Merried Specify: Black 1 Yes 2 Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) ont. Domestic House Wife 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) unk. Colon Alford unk - Lucy Mears 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7519 Heatherfield Dr. Balto., MD Harriette Johnson/friend 21244 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State comotory, cromatory or other place)
Arbutus
Lemetery XXBuriai 2 Cremation 3 Removel from State Baltimore, Md. 2/6 99 4 ☐ Donation 5 ☐ Other (Specify) Pembroke NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility James A. Morton & Sons FuneralHome 1701 Laurens St. Balto., 21217 MD w the state disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, theart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Finat DEMENTIN ALZITEIMEN' TOPE disease or condition resulting in death) Examiner RHEUMOTONO Anton itu Examiner Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting In death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Unknown WEIGHT LOSS þ 24b. Were autopsy findings evallable prior to completion of ceuse of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 □ Yes 2 □ No 25. Was cese referred to medical Be 26. Place of Death (Check only one) axaminer? Other: 4 Nursing Home STATesidenee 8 (Other (Specify) Bospice 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homictde 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my optnon, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO 25410

To the Hospital or Atta within 24 hours after de To the Funeral Directo complataly filled in by the

Division of Vital

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death

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Mouleal Examiner must be nothing all

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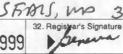
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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



3460 Ellicott Center Drive Ellicott City, MD

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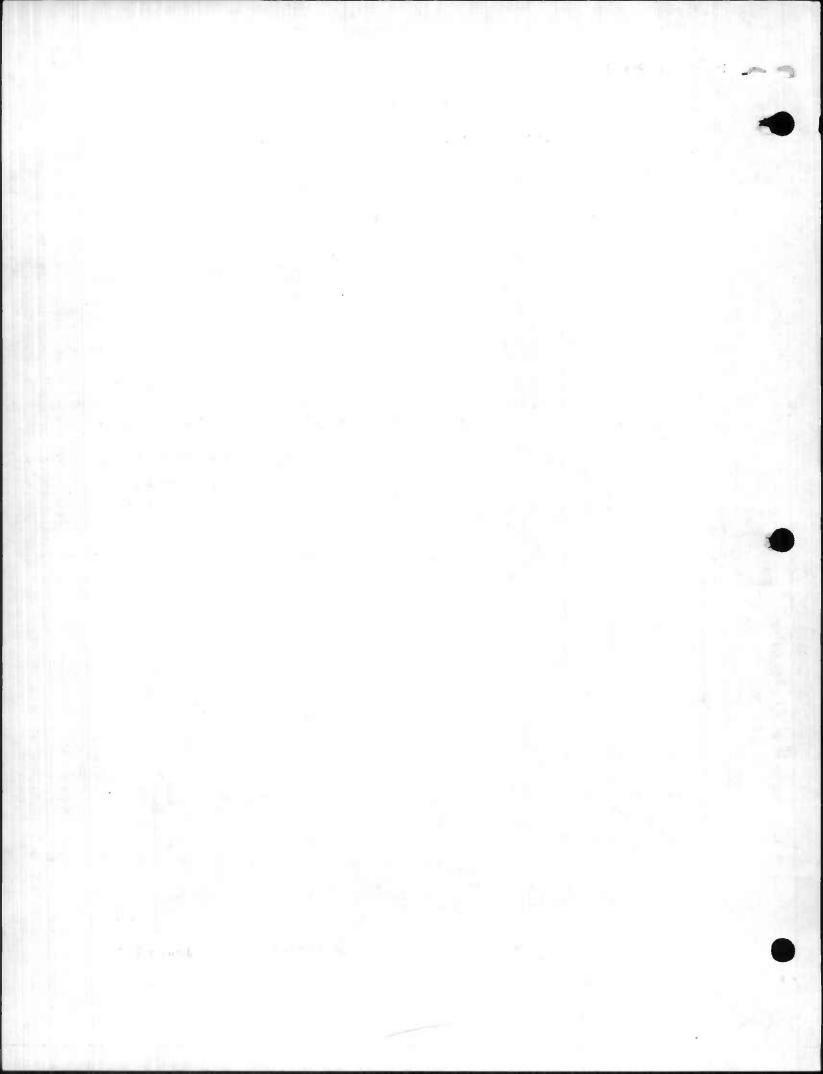
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 02827 Item#29d per Phy G768 2/4/99 EW Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Lillian M. Burdinski 28 1999 8:20H JANUARY /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris At Mercy Hospital Baltimore 8. Date of Birth (Month, Dey, Year) Nov. 5, 1924 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F 218 12 6811 74 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits r 28a-f show 1 No 2 No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 end 2 should be filed within 72 hours after deeth with nent of Health and Mental Hyglene.

Int: If Item 27 Is marked other than "natural", or items 23a or lary or other traumatic event, the Medical Examinar must be a 1234 Patapsco Street 21230 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus Black, Whita, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 25 No Specify: þ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sales Person Retail Sales 10th 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be HINDINSKI, LILLIAN Lillian M. Schuster John Jacobs 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent'a Neme/Reletionship (Type, Print) daughter 1628 Tieman Drive Mary B. Martin / Glen Burnie, Maryland 21061 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ortant: If I Important: H any Injury o Glen Haven Memorial Park 1/29/99 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ramerolish se, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiac or respiratory arrest, . List only one cause on each line. male 23a. Part1. Enter the disees shock, or heart tailure. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Cury 4 month disaese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. physician Physician/Medicai the Due to (or es e consequence of): 65 080 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown signed t Records. þ 24b. Were autopsy tindings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed has 1□ Yes 2 No certificate 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes case reterred to medicat examiner? 89 26. Place of Deeth (Check only one) STELLA MARTS AT MERCY Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funerai 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Netural 5 Pending r death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attention within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 ☐ Hom!cide filled in 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Du 4 Ihr MO D40854 January 28,1999 30. Nerge and eddress of person who completed cause of death (Item 23a) (Type, Print) Bultwere Rusebus Md 21202 301 St ParPl N 32. Registrar seignature 31. Date filed (Month, Day, Year) State 4 1999 FEB Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** Jan /Medical ity Name it not institution, giva street and a 4b. City, Town, or Location of Death 4c. County of D Examiner imore 6. Sax If Under 8. Data of Birth 7. Aga (In yrs. last birthday) 9. Birthplace (Stala or Foraign **Funeral** Months Davs 1 M 2 F Director da Usual Rasidance of Decedant 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County Baltimore 1 Yes 2 No Director 10e Street and Number 101. Zip Code 10g. Citizen of What Country? Ida Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yas, Giva Yaar or Dalas: Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
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ASSUMBLE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) ondary (0-12) Collega (1-4or 5+) 18 Mathar's Nama (First Middle Meiden Sumama) 17. Father's Nema (First, Middla, Last) Garlano Informent's Neme/Relationship (Type, Print) ddress (Street and Numb or Rural Routa Number, City or Town, Stata, Zip Code) Fonso 20b. Plece of Disposition (Nema of cematary, crematory or other 20a. Mathed of Disposition 20c. Location - City or Town, State 1 Burial 2 Crefnation 3 F 4 Donation 5 Othar (Specify) 3 Ramoval from Stata peral Sarvice Lie 21. Signatura of Fd diseasa, or complications that caused tha daath. Do not enter tha mode of dying, such as cardiac or raspiratory arrast feitura. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical io genic Examiner Dua to (or as a consequence of) Examiner Pas Sequentially list conditions, if any, laading to Immadiate causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or as a consequent Dua to (or as a consequence of): anterin Physician/Medical Se PSis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yes 2 19 No 1 Yas 2 No 25. Was casa rafarred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 10 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28c. tnjury at Work? 28d. Describe how injury occurred 1 PNatural 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated. (Check only one)

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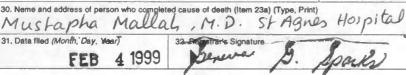
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29b. Signatura and titla of certifiar

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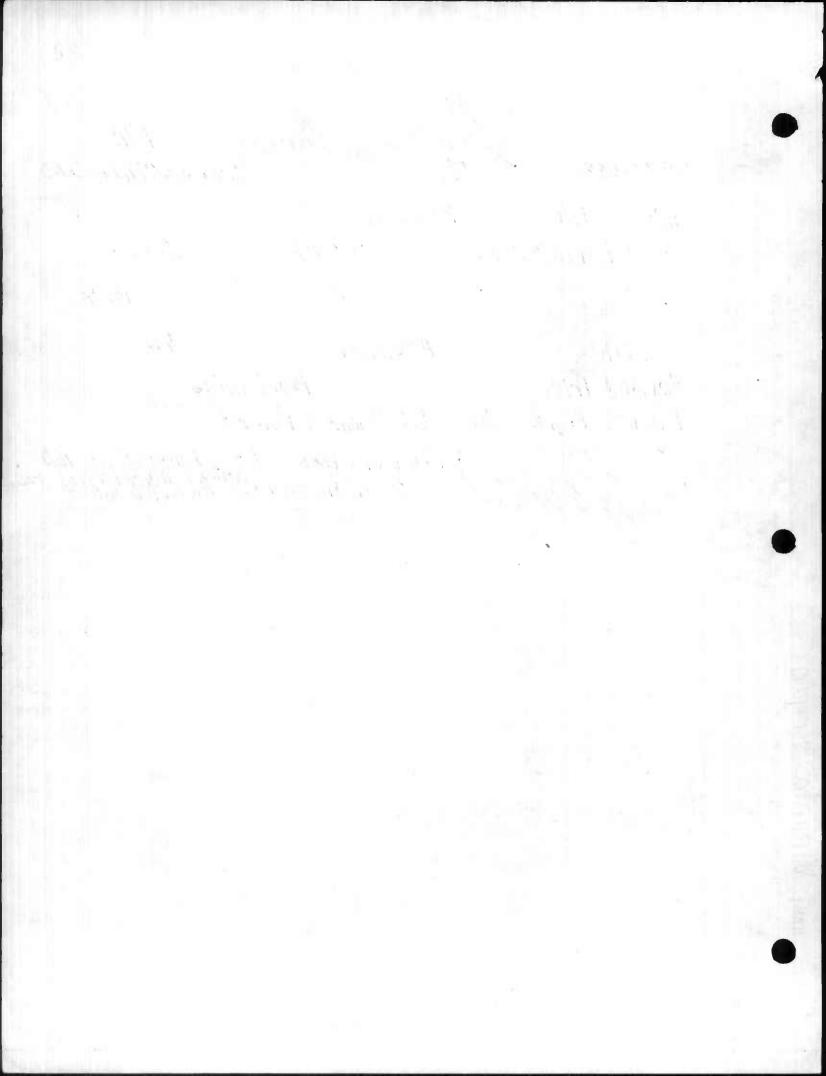
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29c. Licensa number

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29d. Data signed (Month, Day, Year)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 9 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Year Month ESPUARY 2 Elizabeth Bates 1999 10:45 PA 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death Rosedale

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Limore 7. Aga (In yrs. last birthday) Sauge If Under 1 Year 6. Sex 5. Social Security Number Months Days 1 M 2 F 220-12-4288 05-16-21 Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits t□Yas 2□No MD NA Baltimore 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 1815 Weyburn Road 21237 USA Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 € No If Yas, Giva 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yas 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Custodian Public Schools 17. Fethar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Walker John Sarah Harris 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 21237 19e. Informant's Name/Ralationship (Type, Print) Samuel Bates, Jr. 1815 Weyburn Road Baltimore, Maryland 20b. Place of Disposition (Nama of cemetery, crematory or other pleca) 20c. Location - City or Town, Stata 20a. Method of Disposition Data H Burial 2 Cramation 3 Ramoval from Stata Voshell Mem. Gardens 02-08-99 Dundalk, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signatura of Funaral Sarvice Licensee 20 WM.C. March FH 1101 E. North Avenue 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not anter the mode of dying, such es cerdiec or respiretory arrest, shock, or heart failure. List only on cause on each line. Approximete Intarval Batween Onsat and Death Immediata Causa (Final disease or condition resulting in death) Due to (or as a consequanca of): aphylococcal Aure Resi Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaase or Injury that initiated evants rasulting In daath) Last Dua to (or as a consequance of): Wound INtection Dua to (or as a consequanca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Cancer 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Cchcer 1 Yas 20 No 1 ☐ Yas 2 No 25. Wes casa rafarred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of 1 Netural 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, ferm, street, factory, office building, atc. (Specify)

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State Registrar

31. Data filed (Month, Day, Year) 4 1999

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30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

29c. Licansa number

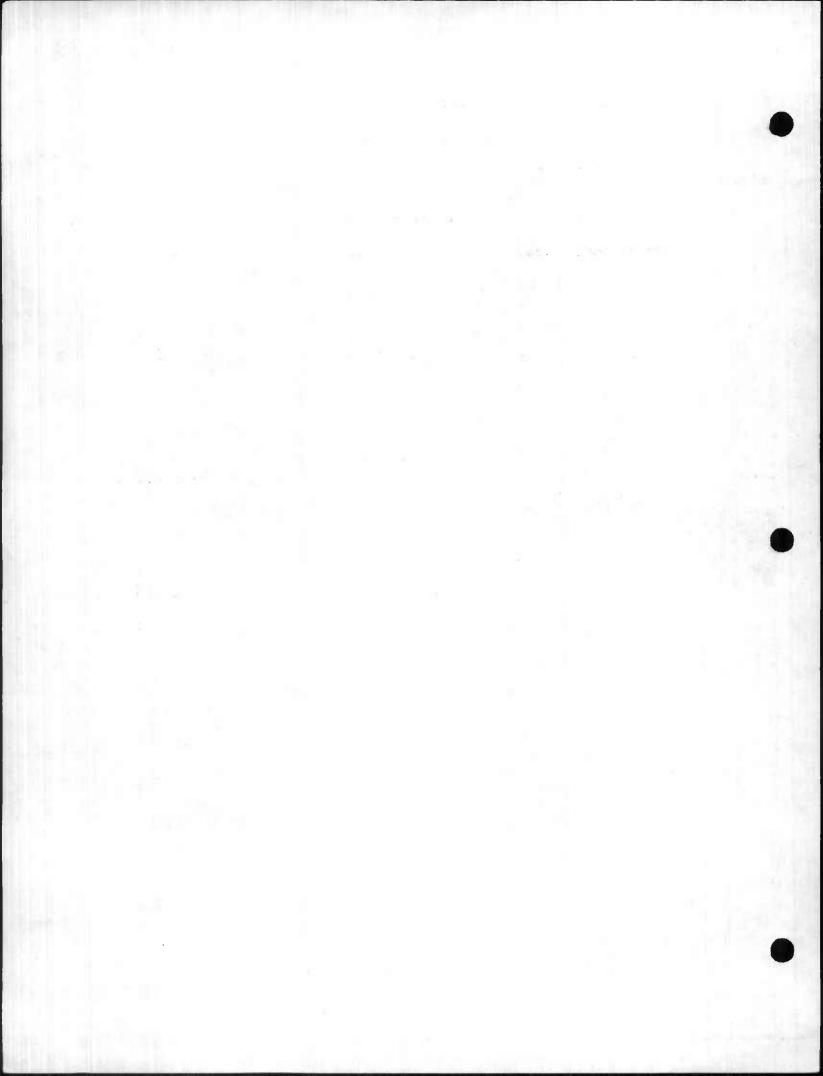
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1 Kertifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my optnion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

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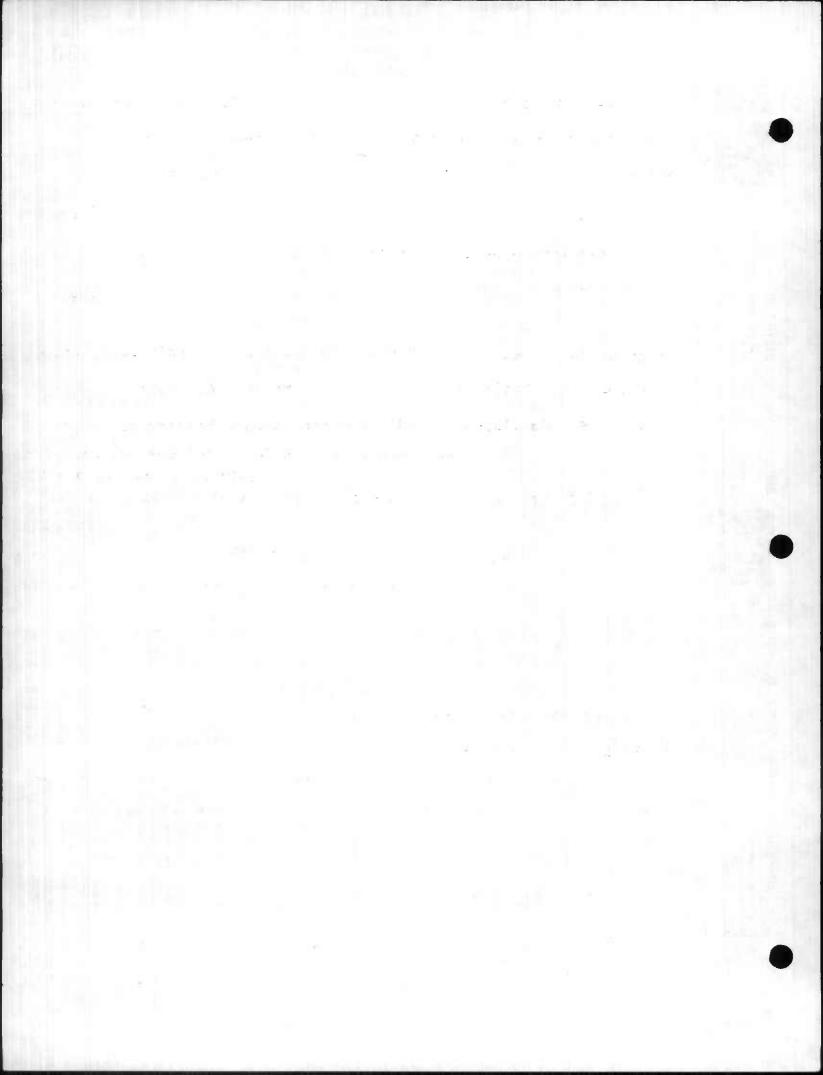
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State of Maryland / Department of Health and Mental Hygiene Q 02830

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pemit. Page Department of Important: if any Injury or page.	21	. Signature of Fu	uneral Service Licar	nsee ()		22.	Name and Addre	ess of Facility	Baltimo	re, Ma	ryla	nd 21202
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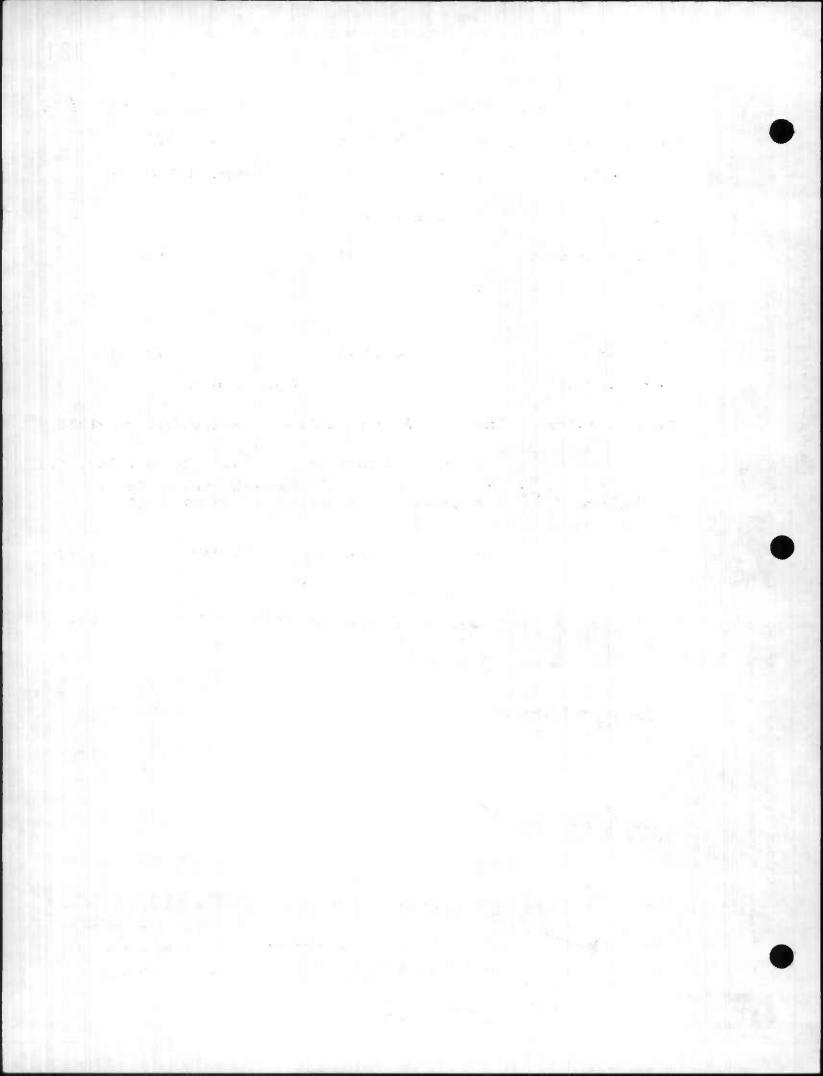


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			State of Maryland		tment of ficate of		Mental Hy	gieney y Reg. No.	UZ	831
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Division	tel or attending P rs after death. el Director: After t led in by the funera Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At ho- building, etc. (Specify	me, ferm, stree	t, fectory, office		28f. Location City or To	(Street end Numb wn, Stete)	er or Rurai	Route Number,
	Hospi 4 hou Funer tely fill	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examir	lcian: To the best of my knowner: On the basis of examinetiand manner stated.	vledge, death o ion and/or Inves	ccurred et the stigetion, in my	ime, date end ple opinion, deeth o	ce, end due to the courred et the time	ceuse(s) end me date and place,	nner as st and due to	eted. the ceuse(s)
	within 2 To the comple	29b. Signature and title of certifier			29c. Licer	se number		29d. Date signe	(Month, I	Dey, Year)
		Ja			D3	6494		FEBRUAR	Y 2,	1999
	1	30. Name and address of person who co	mpleted ceuse of death (Item	23a) (Type, Pr	int) (outh of	was st	- Balhma			•
	State	31. Date filed (Month, Day, Year)	32. Registrer's Signat	ure A	Lan	1				

DHMH 16 Rev 6/95

Registrar

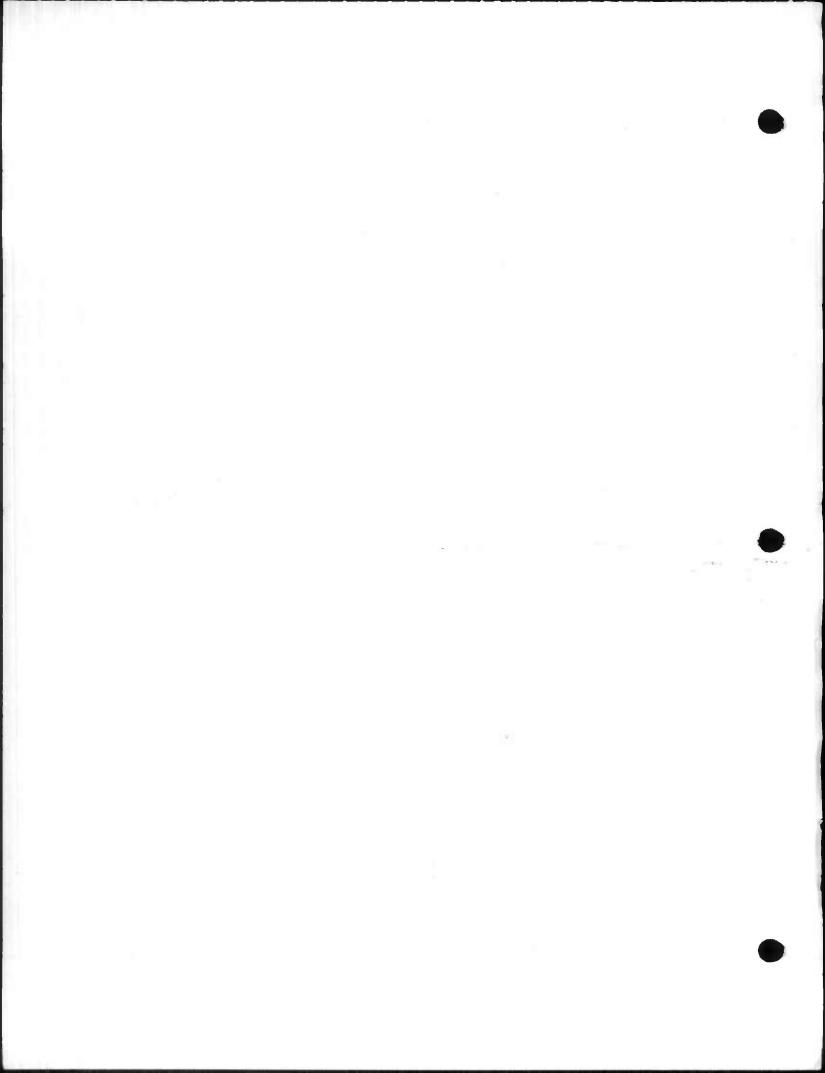


Radney Marcell Briscoe III BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
e funeral director, page 5 should be detached for use as the bunal-transit permit, Pages 1, 2, 3 should	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should
death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - FOR STATE OF REGISTRAR	MARYLAND / DEPART	MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.					
- 1	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATN	TE OF DEATN 3. TIME OF DEAT				
	RODNEY MARCELL H	RISCOE, III		FEBRUARY :		11:55 PM M			
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIFTIN	IPLACE (State or Foreign				
	NONE 1 K M 2 - F	-U- YRS.	9b. CITY, TOWN OR LOCATION OF D	HOURS 52 2/2/1999 USA-MD					
DIRECTOR	GREATER BALTIMORE MEDICA		TOWSON	EATH	BALTIMO				
E	10e. STATE 10b. COUNTY	10c. CITY	TOWN OR LOCATION			10d. INSIDE CITY			
HO	Maryland Baltimore	В	altimore			LIMITS?			
	10e. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN OF WHAT				
ER	15 N. Washington Street	et	21231		USA				
BY FUNERAL	1 X Never Married 2 Married FORCES?	ENT EVER IN U.S. ARMED 1 YES 2 NO WAR OR DATES	If yes, specify Cuban, Mexican, Puarto Rican, etc.						
0	15. DECEDENT'S EDUCATION		SUAL OCCUPATION	166, KIND OF BUSI	NESS/INDUSTRY				
ETI	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	life Do NOT use	ork done during most of working retired.)		- 200				
APL		N/	A		N/A				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		18. MOTNER'S NA	ME (First, Middle, Maiden S	umsme)				
BE (Rodney Marcell Briscoe		Deidra	McKinnon					
10	19a. INFORMANT'S NAME (Type/Print) NIKKI CHILCOAT (STAF		• C • , 6701 N • CF			,MD,21204			
	20a. METNOD OF DISPOSITION 1 □ Burlal X X Cremation 3 □ Ramoval from State	20b. PLACE AND DATE OF	F DISPOSITION (Name of	- V	ATION — City or To				
	4 Donation 5 Other (Specify)	GREEN MO	er place) UNT CREMATORY	7 2-4 BAT	ro. MD.	.21202			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FA	CILITY					
0	· R. D. Rutt		HENRY W.JEN 4905 YORK F	NKINS AND	SONS C	OMPANY			
CERTIFICATION	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, present fellure. List pnly one cause pn each line. Approximate interval Batween Onast and Death disease pr condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								
ERTIF	CAUSE (Disease or injury that initiated events resulting in death) LAST								
	PART if. Other significent conditions contributing	to death but not resulting in	the underiving cause given in	Part I. 24s, WAS AN A	LITOPSY 24h	WERE AUTOPSY FINDINGS			
CAL			/	PERFORM	ED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
8				1 TYES 2	NO	OF DEATH?			
2	DID TOBACCO USE CONTRIBUTE TO C	AUSE OF DEATH YES	NO UNCERTAIL	N D	}	1 YES 2 NO			
¥	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH							
Sic	EXAMINER? 1 YES 2 NO HOSPIAL: 1 Impetiant		OTHER:	8 Other (Specify)					
Y PHYSICIAN: MEDIC	1 Natural 5 Pending		OF 28c. INJURY AT	26d. DESCRIBE NOW IN.	JURY OCCURED				
FED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — Af home, farm, streef, factory, office building, etc. (Specify) 28a. PLACE OF INJURY — Af home, farm, streef, factory, office City or Town, State)								
COMPLETED	29a. CERTIFIER (Check only one)								
8	000) 2 MEDICAL EXAMINER: On the trasts	exemination and/or investigation	In my opinion, death occured at the	time, data and place, and	due to the cause(a)) and menner as stated.			
29c. LICENSE NUMBER D35514 29d. DATE SIGNED (Month, U									
-	NAME AND ADDRESS OF PERSON WHO COMPLETED C	USE OF DEATH (ITEM 27) (Type, I	rint)	e 210	092				
		RÁMOS SIGNATURE	don to		1				
	FEB 4 1999	Denve B.	popular						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** JOHN W. BACIGALUPA 31, JANUARY 1999 6 PM /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANOR CARE ROSSVILLE BALTIMORE BALTIMORE Hours Min. 8. Date of Birth (Month, Day, Year) 9 / 9 / 0 3 If Under 1 Year Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1.8 M 2□ F Months 215-07-5550 Yrs. 95 MARYLAND Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at 1⊠Yes 2□No Director N/A BALTIMORE 10g. Citizen of What Country? 10e. Sfreef and Number 10f. Zlp Code 2439 FLEET ST. 21224 U.S.A. Funeral 14. Race - American Indien. 12. Was Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ₹ No If Yes, Giva Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 M No Specify: Specify: þ 3 MWidowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Collega (1-4or 5+) Elementary/Secondary (0-12) STEEL FABRICATOR STEEL 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fether's Name (First, Middla, Last) Be should be f LOUIS BACIGALUPA LOUISE CUNEO 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2 st Depertment of Health and Important: If item 27 is n any injury or other traun MRS. RUTH BONNER 2320 FRANKLINS CHANCE CT. FALLSTON, MD.21047 20b. Place of Disposition (Name of cematary, cramatory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 2/3/99 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD. 21224 23a. Part1. Enter the disease, or some shock, or heart failure. List plications that caused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, one cause on each lina. Approximate Interval Between Onset and Death Physician Immediata Causa (Final disease or condition rasulting In death) /Medical **Examiner** Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Disease or Injury that initiated evants resulting In death) Last Due to (or as a consequence of): ed by the attending physicial edetached for use as the buriel-Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detach 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No g of Vital Records, 24b. Ware autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed page 2 s this certificate has Physician: 25. Was cese referred to medicel axaminar? Be 26. Placa of Death (Check only ona) Othar: 4 Suursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Attending 1 Natural 2 Accident death. 1 □ Yes 2 □ No spital or Attenditions ster death. 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 T Homicida To the Hospital of within 24 hours e To the Funeral D completely filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 30. Name and address of person who completed ceuse of daath (Itam 23a) (Type, Print) BELDINA Ballo 18

DHMH 16 Rev 6/95

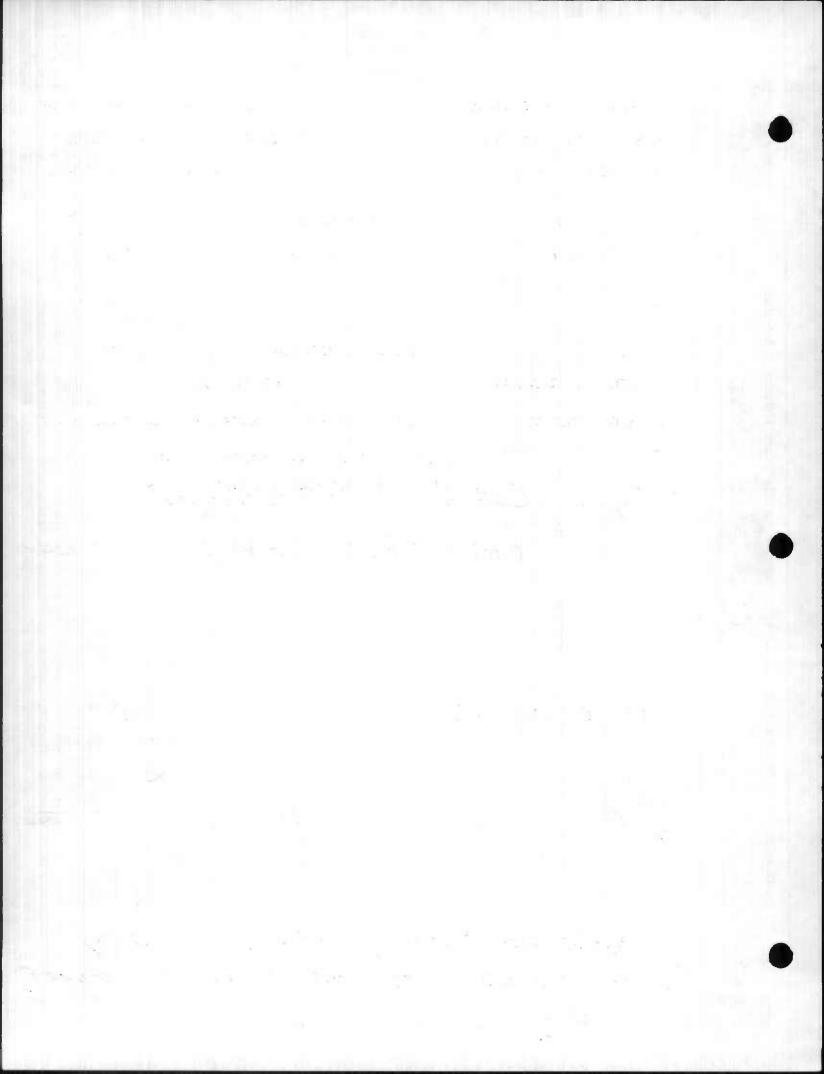
State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

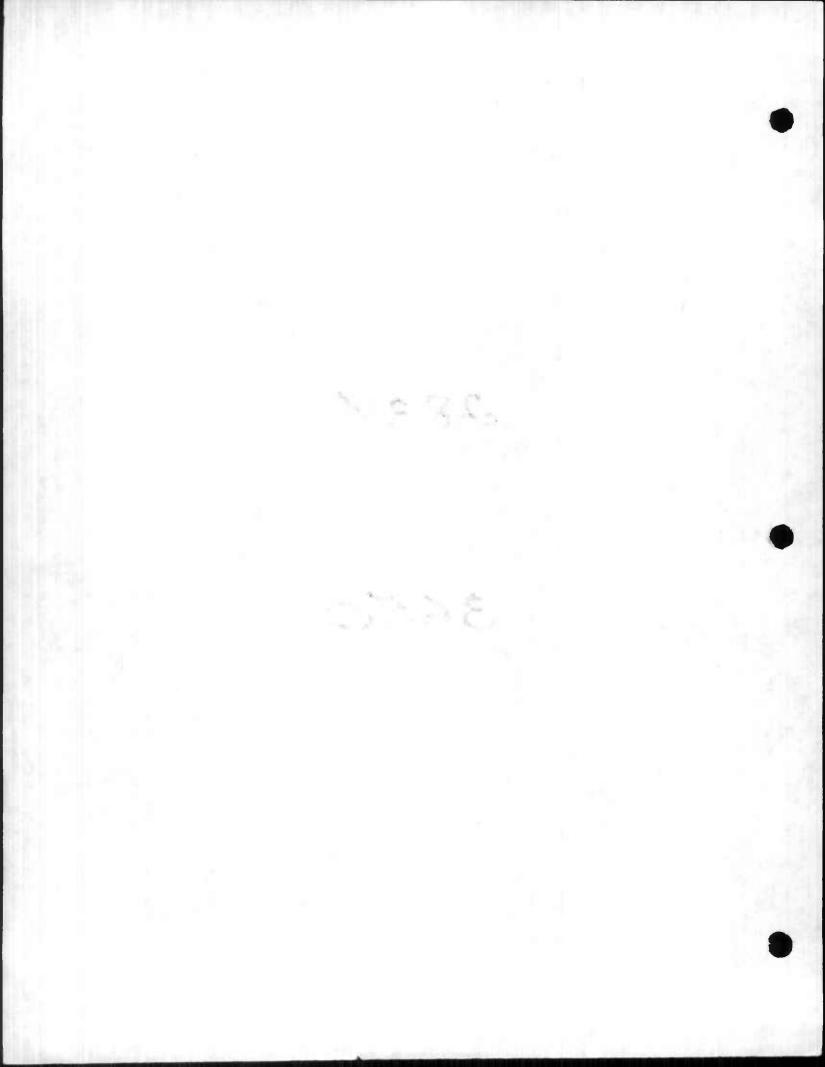
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VOID
CERTIFICATE #

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CERTIFICATE #

3650_



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Deeth 1. Decedent'e Name (First, Middle, Last) 3. Time of Death Month Carroll 1630 1999 ames February 2 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 7. Age (In yrs. lest birthdey) 40 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 1 XM 2□ F Deys Hours 219-68-8273 05-06-58 MD Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No MD NA Baltimore 10e. Street end Number 10f, Zip Code 10g. Citizen of What Country? 1045 Cameron Road 21212 USA 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10th Grade Chauffeur Gas Attendent 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) James F. Carroll, II Henrietta Ennis 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 1 2 1 2 Henrietta Ennis 1045 Cameron Road Baltimore, Maryland 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete N☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete Kings Mem. Pk. Cem. 02-06-99 Randallstown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, 21 Signature of Funerel Service Licenses Maryland 21202 WM.C.March FH 1101 E. North Avenue e. Pert1. Enter the disease on complications that eaused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. disponly one cause on each line. Approximete Interval Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) ram negative Due to (or es e consequença of) neumoni a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in deeth) Lest Due to (or es e consequença of) aspiration Due to (or as a consequence of): 3 days Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? positive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evallable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? End stage renal disease esophagitis t□Yes 200No 1 Yes 2 No candida 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetlent 3 DOA 1□ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dale of Injury (Month, Dey Year) 28b. Time of 27 Manner of Deeth 28d Describe how Injury occurred 28c. Injury at Work? 1 Abeturel 2 Accident 5 Pending investigation 1 TYes 2 No 6 Could not be determined 3 ☐ Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, Stele) Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated. 2 Madical Examinar: On the besis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the cause(s) end menner stated. 29e. Certifier

Division of Vital Records, P.O. Box 68760, s certificata has b or Attending Physician: this funeral After after death. by the f in 24 hour. the Funeral Direc-

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23s or 28s-f ahow the Magical Examiner must be notified at

Director

Funeral

à

Completed

the Maryland

with

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglena. Important: if item 27 is marked other than "naturel", or items 23s any injury or other traumatic event, the Marked Page 23s page.

Physician

AMEDICAL

Examiner

Physician/Medical Examiner

þ

Completed

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Certification:

edicai

To the Hosp within 24 hou To the Fune completely fi

29b. Signature end title of cartifier

29d. Date signed (Month, Day, Year)

30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print)

February 2, 1999

21287

BALTIMORE, MARYLAND

SLOH 1 HONS Hopkins

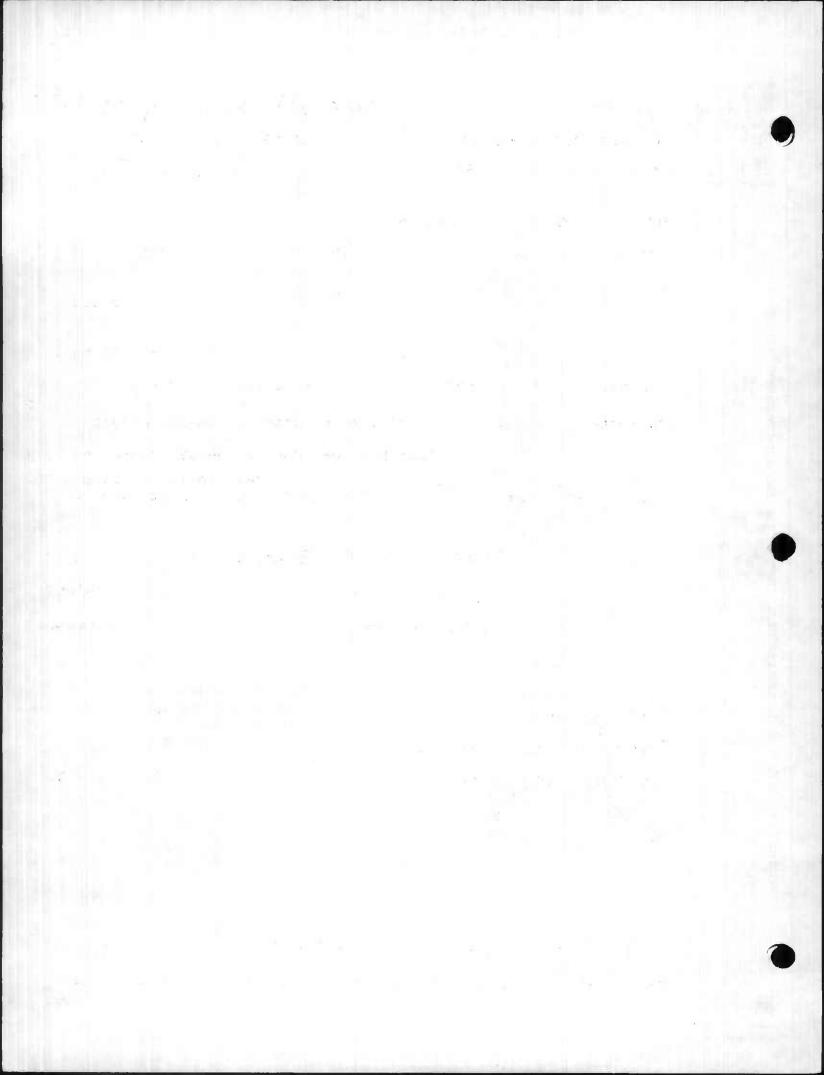
Bart Suff
31. Dete filled (Month, Day, Year)

(Check only one)

32. Registrer's Signeture

DHMH t6 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** Goldie Cotton 12.05 Vanuary /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deetly 4c. County of Deeth Examiner IMORE BALTIMORE NUNCH NOME AND NOSPITAL If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs Months 1□ M 21XF 88 214-26-6032 VA Director 08-26-10 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SICIAN 1400 E. Madison Street Apt.606 21205 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes ZV No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Beautician Self-employed 10th Grade 18 Mother's Neme (First Middle Maiden Sumama) 17. Father's Neme (First, Middle, Last) Unknown Case Pop 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) John Cotton+William White 1400 E. Madison Street Baltimore, Maryland 20b. Place of Disposition (Name of cometery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete altimor W Burial 2 ☐ Cremetion 3 ☐ Removel Irom Stata 4 ☐ Donetion 5 ☐ Other (Specify) Kings Mem. Pk. Cem. 02-06-99 Randallstown, MD 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signeture of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue 23a. Paint 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Deeth **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical · ACUTE MYOCARDIAL INFARCTION **Examiner** Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as e consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 4 Unknown 1 Yes 2 No 3 Probebly Records, þ The law requires 24e. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed complation of causa of death? 20 No 1 Yes 1 Yes 2 No Division of Vitai 25. Was case referred to medical examiner? 80 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 10 1/ Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a: Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Attending 1 Netural ...cepital or Atten in 24 hours after death • Funeral Director: A yiely filled in by the " death. A □ Accident 1 TYes 2 □ No 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, lerm, etreet, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

**D Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signetura and title of certifier 0 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Dr . Bonacum/MD Julie 11) VYh adwas

State Registrar 31. Dete filed (Month, Day, Year)

DHMH 16 Rev 6/95

32. Registrar's Signature

4 1999

B. Sparks

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 2 2 3 7

			Certificate of Death		Reg. No.	12031							
Г	Dharaisi		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ith	3. Time of Death							
L	Physici /Medic		Linnie (uffee	February	1,1999 Year	12:45							
	Examin		4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town,	or Location of Death	4c. County of De	efh							
1_		_	8220 Brattle Road Pikesu	ille		more							
	Funeral		5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 H Months Deys Hours N	lin. 8. Dafe of Birth (Month, Day	year) (/)	irthplace (State or Foreign Country)							
L	Director		Usual Residence of Decedent	Deplembe	11/190 /1	asyland							
	/land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
	Man	ector	Maryland Ballmore Pikesville			1 Tes 2 No							
	or 28	Direc	10e. Street and Number 10f. Zip Code		10g. Citizen of Whet C	Country?							
	death with the Maryland ms 23a or 28a-f show rman to northed		8220 Brattle Road 21208		USK	1							
		Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Am Bieck, Wh	nerican Indian, ite. etc.							
20	hours after ural, or its	by Fu	1 ■ Never Married 2 ■ Married 1 ■ Yes 2 ■ No Specify:		Specify: 7	/ (
5-0020	0 5		3 Wildowed 4 Divorced Year or Dates:		10h Kind at Busin	ack							
15		Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Busines	s/industry							
212	yene.	E O	Elementary/Secondary (0-12) Un Known DISabled DISabled		never	worked							
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lar	Vanta Vanta rked rice	ToE	Jacoh luffee Dora	thu (-	prnet	+							
lan	2 sho end is me		19a. Informant's Name Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Number	r. City or Town, Stete.	Zip Code)							
2	and ealth 127 har tr		Veronica Jackson-Sister 8220 Brattle Ra	ad, Fike	suite Me	rykn/21208							
O	f of H		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Place of Disposition (Name of cemetery, cremetory or other place)	E hrugery	20c. Location - City o	Town, State							
tim	tman tant:		4 Donation 5 Other (Specify) Arbutus Mom. fark	6,1999	Daltimo	re Marylan							
Balti	Department of the property of		21. Signature of Funeral Servica Licansee 22. Name end Address of Facility 1701 McCyllon	lous lass Fi	meral Se	ruice							
	ubl w u		arlow (Loughel	2121	7	ryland							
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line.	diac or respiratory ar	resf,	Approximate Intervel Between Onset and Death							
	Physician /Medical		Immediate Cause (Final			Onset shd Death							
	Examiner		disease or condition resulting in death) a. Myo ear offer Juffer chow										
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	and Aransit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)	e poor e	TWO TO								
0	100				Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Otheroselevatic, Carolio -V	ascula	v olisea	10					
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	within 2 To the compla	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Moi	nth, Day, Year)							
	- > - 0		David J. Penn mo D2992	8	2/4/99								
v v	2												
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David J. Penn 3635 Old GTRd Suite 6	10 Dik	esville 1	1D21208.							
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $9\ 9$ Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician** 8:12 PM 1999 George Albert Dunty January 31 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Bultimore Hospital Center Harbor If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months 1 MM 2 □ F 216-36-7283 Director Feburuary23,1938 MD Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exertise in that to notified at any injury or other traumatic event, the Medical Exertise in that to notified at 10b. County 1 ☐ Yes 2 🖾 No Directo Baltlimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 1213 Maiden Choice Lane U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces?

1 M Yes 2 D No 1956-62 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Collection Supervistor Tax&Credit COllection 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) John William Dunty Matilda C. Miller 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1213 Maiden CHoice Lane, Baltimore, MD 21229
of Disposition (Neme of Date 200. Location - City or Town, State Cynthia Langhirt ExWhife 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 1 Burlal 2 Cremation 3 Removal from State 2/4/99 Owings Mills, MD Garrison Forest Veterans 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 21. Signeture of Funeral Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 plications that caused he death. Do not enter the mode of dylng, such as cardiac or respiretory errest, one cause on each line. Physician /Medical Immediate Cause (Final Coronary Years Heart disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t d be detect 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 1 X Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homlcide 29a. Certifier (Check only one) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and manner as stated. Medical 2 Medical Examinar: On the besis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier

AS 244 1614 A24 February

Street, Buttimore, Maryland 21225

To the Hospital within 24 hours a To the Funerel D

Division of Vital Records, P.O. Box 68760

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I or Attending Physician: after death. Director: After this certific

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State Registrar Danny

31. Date filed (Month, Dey, Year)

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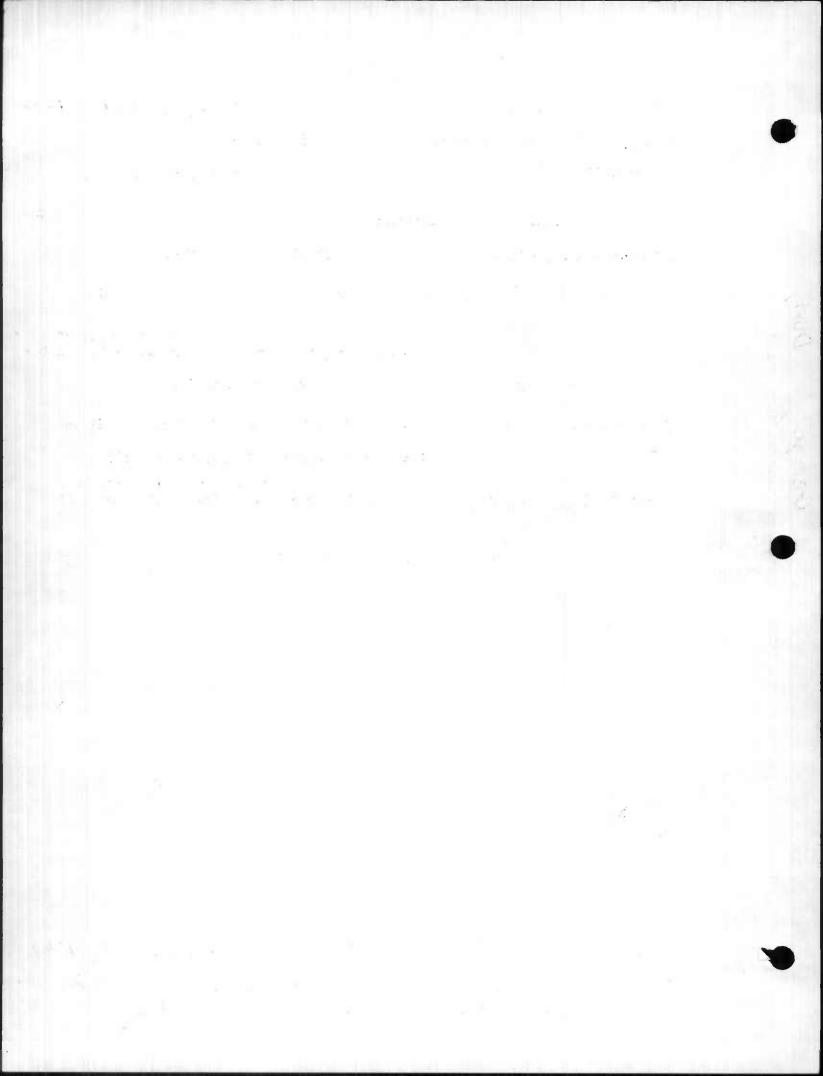
30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

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South

32. Registrer's Signeture

Hanover



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Day Year Rosemany Devers Feb 5-45pm 1000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death areater Baltimore medical Center Baltimore TOWSON 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 1 M 2 F Hours Min 216-28-8939 67 July 9, 1931 Maryland Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore Owings Mills 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Moser Lane 21117 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Robert L. Kaufman Rose Mary Marino 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Eugene N. Devers - husband 206 Moser Lane, Owings Mills, Md. 21117 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens Feb. 6,1999 Finksburg, Md. 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
Eckhardt Funeral Chapel Gitt 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final disease or condition resulting in death) 3WKS nearc Stove Due to (or as e consequenca of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) years Diabetzs mellets Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Chronic failure renal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 25 No 1 Yes 20 No

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

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harms 23a or

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Hygiene.

Pages 1 and 2 should be I nant of Health and Mental I int: If Nem 27 is marked of

permit. Pages 1 and 2 a Department of Health an Important: If Item 27 is any Injury or other trau 9055.

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

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/Medical

Examiner physician and s the burial-transit 980 ŏ 94 signed by t page certificate Certification: To this After Director: /

Physician/Medical à Completed Be 25. Was case referred to medical 27. Manner of Death

the death certificate be executed 68760 Box P.O. Records, of Vitai Division or Attending death. 24 hours after of Funeral Direction of the Filed in by edical

To the Hospital o within 24 hours af To the Funeral Dicompletely filled in

DHMH 16 Rev 6/95

State Registrar 29b. Signature and title of certifian

Hospital:

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

29c. License number D20650

28c. Injury at

t≝ Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Data signed (Month, Day, Year) Feb 4

28t. Location (Street and Number or Rural Route Number, City or Town, Stele)

30. Nama and address of parson who completed cause of death (Item 23a) (Type, Print)

David D. collins 6701 N-Charles St 44101 Ball. Md 21204 MO

31. Date filed (Month, Day, Year)

1 Yes 2 No

1 Netural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

32. Registrar's Signature

1999

1 Anpatiant 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day **Physician** 12:30am JAMES W. FLINT FEBRUARY 2,1999 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner GILCREST NURSING CENTER BALTIMORE TOWSON If Under 1 Yeer if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Min 10XM 2□ F Months Days Hours Yrs. 75 Director 213-16-4051 4-7-23 MD. Usual Residence of Decedent the Meryland 2 should be filled within 72 hours after deaving the should be filled within 72 hours after deaving the standard other than "natural, or items 23s or 28s-f show its marked other than "natural or hottled at 10d. inside City Limits 10a State 10c. City, Town or Location 10b County 1 XYes 2 No Director N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3303 SEQUOIA AVE. 21215 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck. White, etc. 1 ☐ Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) traumatic avant, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) -12--0-BUTCHER FOOD Maryland permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic avant, phos. 18. Mother's Name (First, Middle, Melden Sumame) 17. Father's Name (First, Middle, Last) WILLIAM FLINT NELLIE HALL 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) VERA FLINT(WIFE) 3303 SEQUOIA AVE. BALTIMORE, MD. 21215 Baltimore, 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20a, Mathod of Disposition 20c. Location - City or Town, State 1 N Buriel 2 □ Cremetion 3 □ Removel from State ARBUTUS MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 2-5-99 BALTIMORE, MD. 22. Name and Address of Fecility PHILLIPS FUNERAL HOME, P.A. 21, Signeture of Funeral Service Licenses CFSP eth 1721-27 N. MONROE ST. BALTIMORE, MD. 21217 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediete Ceuse (Final Concer 3 months disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or es a consequence of) 68760, law requires that the death certificete be Due to (or as e consequence of): resulting in death) Last by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 3 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed peed 108 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No cartificata of Vital Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) NOSOICE 10 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral 28e. Dete of Injury (Month, Dey Year) 27 Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? Certification: or Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident Director: 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 3 ☐ Suicide Piaca of Injury - At home, farm, street, fectory, office building, etc. (Specify) efter 4 T Homicide To the Hospital or within 24 hours eff To the Funeral Di completaly filled in Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) and manner as stated.

2 Medicat Examins: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) end menner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of a , mo ed cause of death (Item 23e) (Type, Print) 30. Name and eddress of person who compare

6701

32 Registrar's Signature

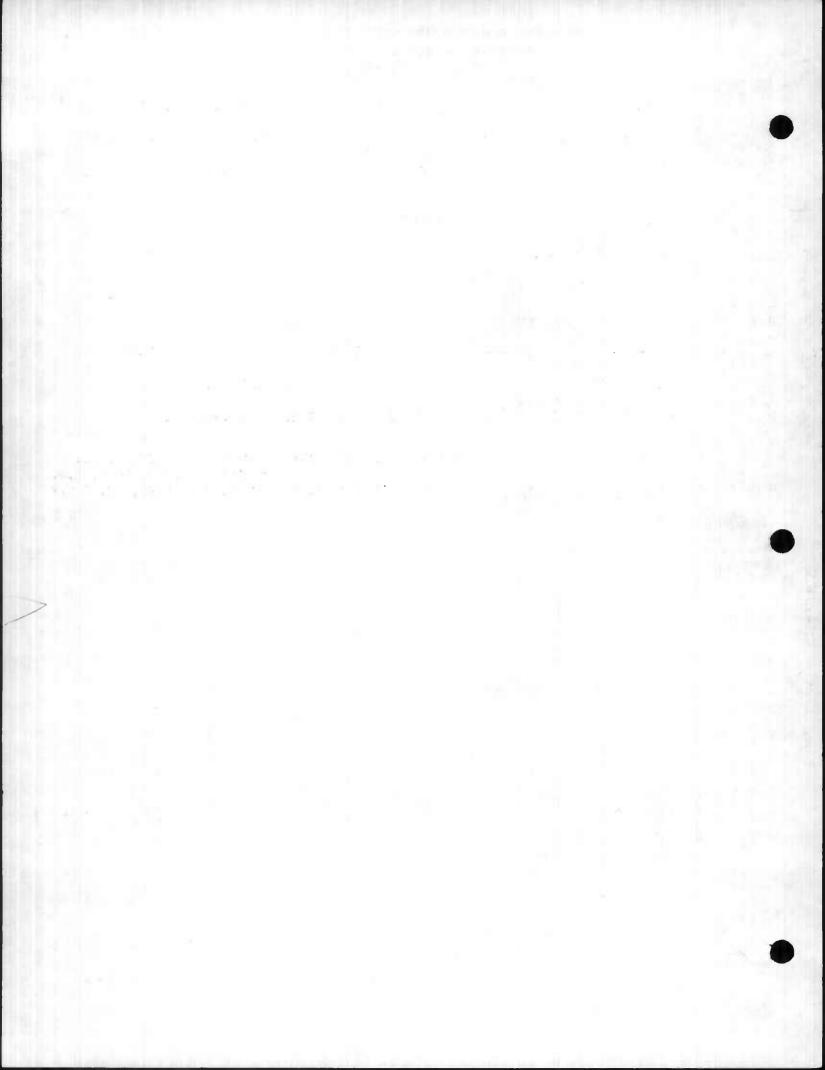
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Charles St. Balto and 21204

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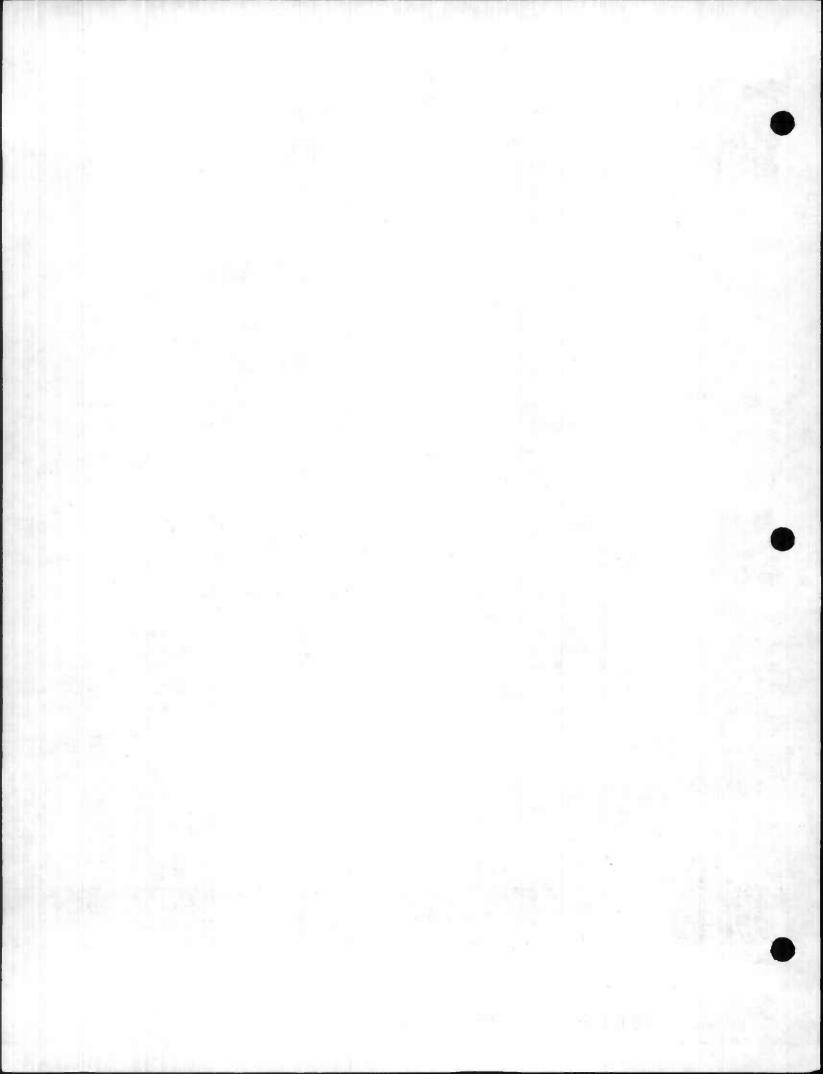
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Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** LTHEL 13:46 FISCHER February 2 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner THE JOHNS HOPKINS HOSPITAL N/A BALTIMORE CITY If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 29, 19 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖺 F 79 Yrs. 218-03-5247 MARYLAND Director Usuet Residenca of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 ☑ Yes 2 ☐ No Director MARYLAND N/A BALTIMORE 280-1 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8 238 U. S. A. 409 N. CURLEY STREET 21224 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, atc. 11. Meritel Stetus permit. Pages 1 and 2 ahould be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is methed other than "natural", or its any injury or other traumatic event, the Medical Exemina 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11th Grade DEPARTMENT STORE CLERK 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be AUGUST FISCHER CATHERINE FREEBURGER Lo 19e. Informent's Neme/Relationship (Type, Print) (BROTHER) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM E. FISCHER SR. 3410 RAMONA AVENUE, BALTIMORE, MARYLAND 21213 20b. Pleca of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ABurial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK 2/6/99 BALTIMORE, MARYLAND Signature of Funerel Service Licensee 22. Neme end Address of Fecility SCHIMUNEK FUNERAL HOME INC bus 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final ere tro vascu disease or condition resulting in deeth) Examiner Examiner scleroho physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thiury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 80 signed by the at the detached for Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 2 s certificate has 2 No 1 Yes 2 No 1 Yes of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Deeth (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Time of tnjury 28d. Describe how injury occurred 28c. Injury et Work? Division or Attending 5 Pending invastigation after death. 1 Yas 2 No 2 Accident 6 Could not be datamined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, term, street, fectory, office building, atc. (Specify) filled in by 4 Homicide 24 hours & Hospital Medical 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated. completely 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) end mennar steted. (Check only within 2 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES-000 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 600 N. Wolfe Smeet Bottimere, MD 21287 NEIL C. EVANS, MO 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar FEB 0 4 1999

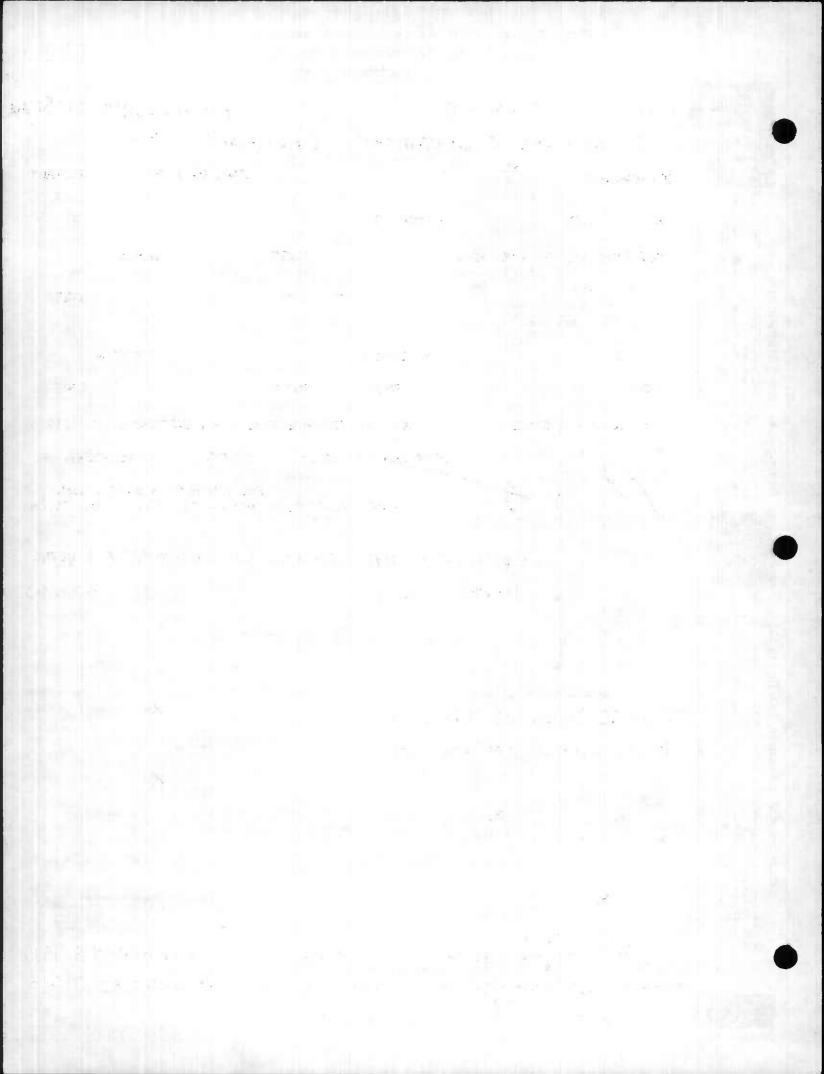
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cto	MD N/A BALTIMORE				A				
Director	10e. Street end Number 10f. Zi	p Code		10g. Citizen of V					
	6007 PARK HEIGHTS AVE. #B-1	21215		U.S	-A.				
Funeral	Armed Forces? If Yes, spi	dent of Hispanic Origin? (scify Cuban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)		e - American Indian, k, White, etc.				
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5	ISAAC STEIN	JOHANN							
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	21. Signature of Fugueral Service Licensee 22. Name a	nd Address of Facility		Jaon a F	DOG THE				
DUCE	0000				ROS., INC.				
	23a Funt. Errar he disease, or complication that caused the death. Do not enter the monahook, or heart failure. List only one cause on each line.	REISTERSTOWN de of dying, such as cardi	iac or respiratory a	rrest,	Approximate Interval Between				
an	anock, or near failure. List only one cause on each line.				Onset and Death				
al	Immediate Ceuse (Finel disease or condition resulting in death) a. OBSTRUCTIVE HYPE	EDTRAPHIC	CARNIC	MYAPA	THY I VEAR				
ier	disease or condition resulting in death) Due to (or as a consequence of		CHRUIC	ו ו טן זוו כ	THE TYPE				
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Examiner	b. HYPERTENSION Due to for as a consequence of				30 yenrs				
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	cause. Enter Underlying Cause (Disease or injury C. Due to (or as a consequence of):								
edical	resulting in death) Lest Due to (or as a consequence of):								
M	d								
ician/Med	Part II Other class March conditions and the second design of the second	and the Bod I	225 DI4	tobassa usa sa	ntribute to the cause of deeth?				
ys	Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying	cause given in Part I.			3 □ Probably 4 □ Unknown				
4	TYPE II DIABETES MELLITUS			Yee 2 No 3 Probably 4 Uni					
Completed by Physician				an autopsy	24b. Were eutopsy findings				
ete	MYOCARDIAL INFARCTION			ormed?	evaileble prior to completion of cause of deeth?				
E					o oronica				
				Yes 2 No	1 Yes 2 No				
Be	25. Was case referred to medical examiner?	Other	eath (Check only	one)					
2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D		Home 5□ Res						
:00	27. Manner of Death 28a. Date of thjury 28b. Time of (Month, Dey Year) Injury	28c. Injury at Work?	28d. Describe	how injury occur	red				
ati	2 ☐ Accident Investigation M	1 ☐ Yes 2 ☐ No							
tiffic	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	ry, office	28f. Location (City or To	(Street end Numl wn, Stete)	per or Rural Route Number,				
Cer									
edical Certification:	29e. Certifier (Check only 1 Certifying Phyeician: To the best of my knowtedge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation	d et the time, dete end ple	ce, and due to the	cause(s) and ma	anner es steted.				
	one) Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death oc	ज्याच्य स्ताति तामिल,	, cate and place,	and due to the cadea(2)				
Σ	29b. Signature and tips of certifier 29b.	c. License number		29d. Date signe	d (Month, Day, Year)				
	CONSOL MD	P1233	3	FERRI	JARY 3, 1999				
	30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)	1000		LEON	71111				
	JOSEPHINE OWUSU-SAKYI, 2401 WEST BE	VENERIE AND	ENUE RA	LTIMORE	E MD 21215				
tate	31. Date filed (Month, Day, Year)	- TUDEINE TIVE	-, tolo, Dr		TIME OF STREET				
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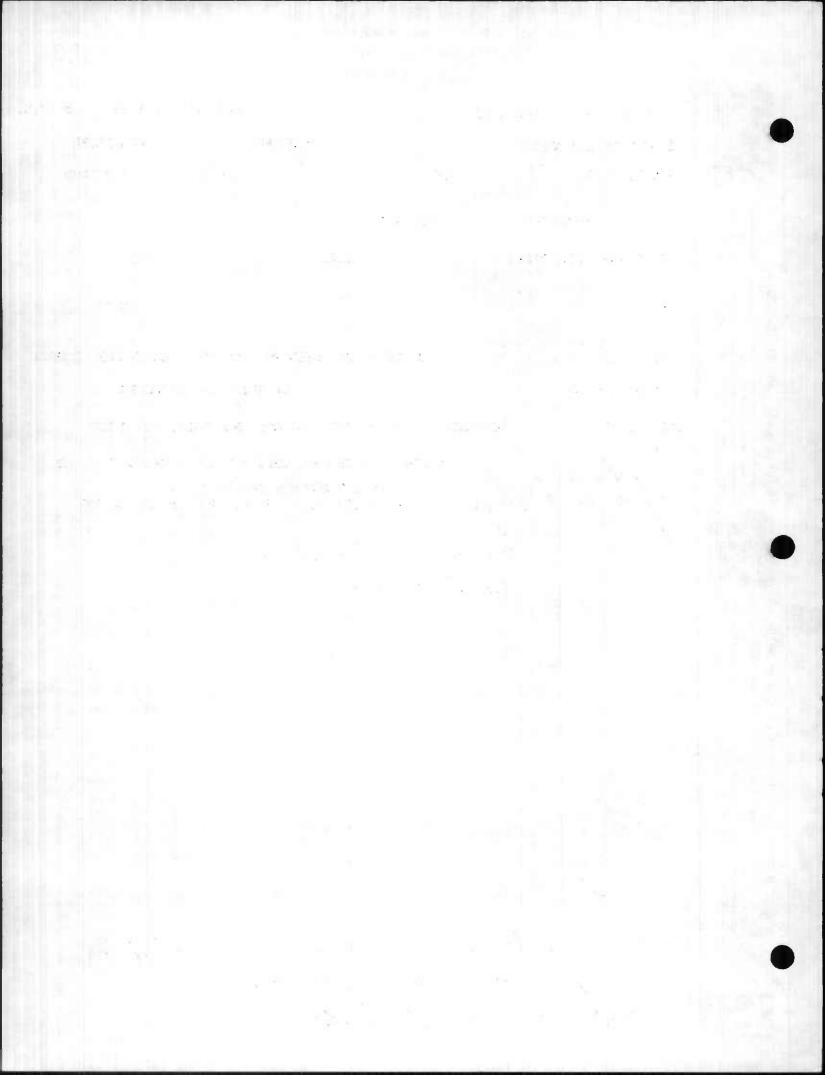
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State of Maryland / Department of Health and Mental Hygiene 9 02843

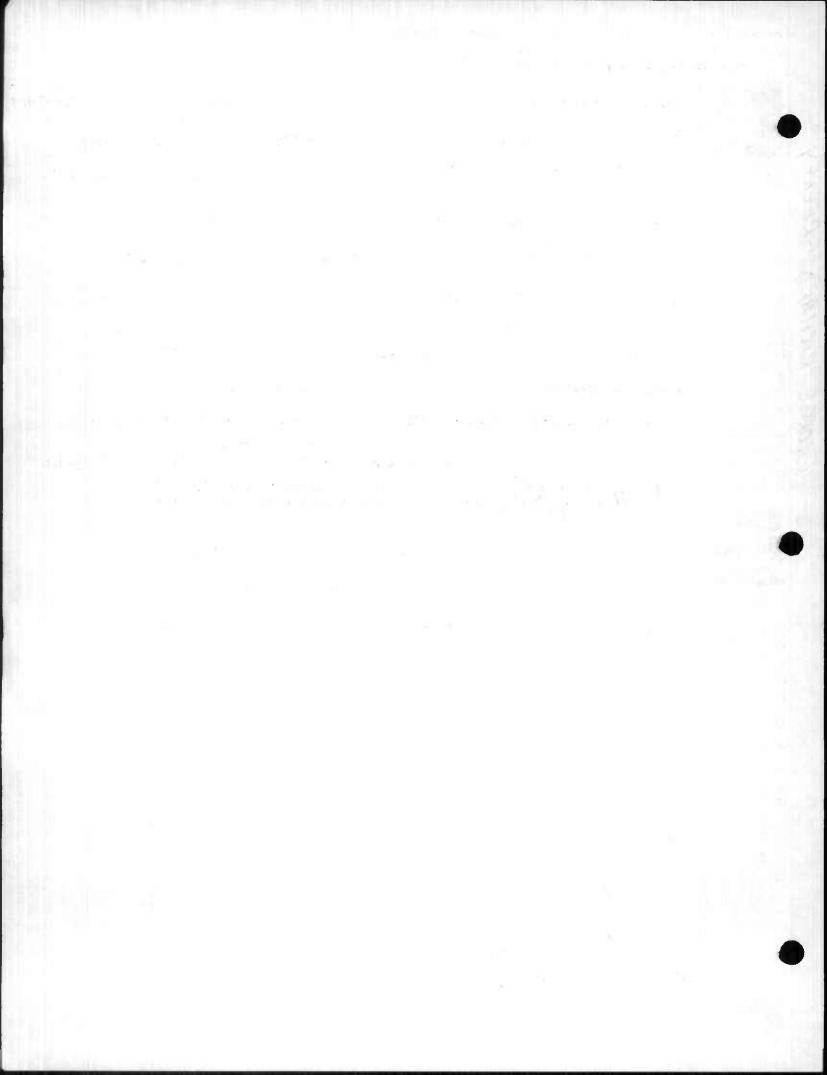
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HERMAN FLORA 19a. Informant's Name/Relationship	t)	BR	ICK MAS	SON/B	UILDING 1				COUNTY
19a. Informant's Name/Relationship					18. Mother's Nar	ne (First, Middle, N	faidan Sumami	a)	
					ELLA EI	IZABETH	NICHOLA	S	
PITEN MPHI	(Type, Print)	198	. Mailing Addre	ess (Street	and Number or Ru	rai Route Number,	City or Town,	State, Zip C	lode)
PREPRIA MENTE	DAUGH	TER 1	306 ROS	SEWIC	K AVENUE	ROSEDAL	E, MD	21237	
20a. Method of Disposition	-	20b. Place o	R 1306 ROSEWICK AVENUE ROSEDALE, MD 212. Place of Disposition (Name of cematar, crematory, or other place) Date 20c. Location - City or T						n, State
1 Suriel 2 ☐ Cremation 3 6 4 ☐ Donation 5 ☐ Other (Spec			,		EM. GAR.	2/5/99	COCKEYS	WILLE	MD
21. Signature of Funaral Service Lice	ensaa	DODIL				2/3/33	COCKETE	ATDDD	110
1/2518	10//		THE 3	JOHNS	ON FUNERA	AL HOME,	P.A.		
Trathe 1	* Huye		8521 I	LOCH	RAVEN BL	D. TOWS	ON, MD	2128	
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resulting in death)	8.	Due to (or es a	consequence o	of):				1	
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resulting in Sautiny East								1	
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Part II. Other eignificant conditions	contributing to death bu	t not rasulting i	n tha underlying	g ceuse gi	ven In Pert I.	23b. Did to	bacco uae cop	rtribute to t	the cause of death
							. /		ably 4 Unknow
								24b. Wer	re autopsy findings lable prior to
						perform	ned?	com	pletion of ceuse
							,	10	Yes 2 No
examiner?	Hospital:			Ott	har	. /			
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1 Naturel 5 Panding	(Month, Day	Year) 280.	Injury			260. Describe no	w injury occur	90	
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4 ☐ Homicida determine	4 Zoe. Flede di inju	ry - At home, fa . <i>(Specify)</i>	arm, street, fact	tory, office		City or Town	reet and Numb n, State)	er or Hurai i	Houte Number,
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29b. Signetura end title of certifiar	1 /1		1	_		2	9d. Date signed	Month, Di	ay, Year)
Musert	tolto, 1	D		1) 3	0910		2/4/	99	
10000	/ /	(d. 11) - 00 h							
30. Nama and addrass of person who	complated ceuse of de	ath (liem 23e)	(Type, Print)	Poho	rt Stalte	MD	111	1 1	
30. Nama and addrass of person who	complated ceusa of de	eath (Item 23e)	(Type, Print)	Robe	rt Stolt	MD Y	11	1-11	
	23a. Part Enter the disaase, or condock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in death) Last Part II. Other eignificant conditions 25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Maturel 5 Panding investigation determined 29a. Certifiar (Check only 2 Madical Examiner) 1 Cartifying P Madical Examiner 29a. Certifiar (Check only 2 Madical Examiner)	23a. Part - Enter the disaase, or complications that caused nock, or haart failura. List only one causal aech lin Immediate Cause (Final disease or conditions as aech lin Immediate Cause (Final disease or conditions as aech lin Sequentielly list conditions, if any, leading to immediate cause. Entar Underlying cause (Disease or Injury thet Initiated events resulting in death) Last 25. 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Was cese referred to medical evaminer? 1 Office the thicked events 25c. Place of Death (Check only office) 25d. Describe to Injury at (Injury E JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. PArt Enter the disease, or complications that Laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause is each line. Immediate Cause (Final disease) Immediate Cause (Final disease) Immediate Cause (Final disease) Immediate Cause (Final disease) Immediate Cause (Final disease) Immediate Cause (Disease) HE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOMSON, MD 2128 23a. PArt Enter the disease, or complications the Cause that death. Do not enter the mode of dying, such as cardiac or respiratory arrast, immediate Cause (Final disease or condition resulting in death) a. Cubral UC Jula GCCI dent Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 24a. Was an autopsy performed? 25. Was cese referred to medical examiner? 10 Yes 20 No Hospital: 11 Inpetient 20 ER/Outpatient 30 DOA Char: A Nursing Home 5 Steatignee 6 Oother (Specify) A Nursing Home 5 Steatignee 6 Oother (Specify) A Nursing Home 5 Steatignee 6 Oother (Specify) 28b. 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Item 7	23P	arti b Per PHY Film G7	State of N 68 2-24-99	faryland /		ment of I	Health and N Death		gieneg g	02	844
Physicia /Medic		1. Decedent's Nama (First, Middle, La George Richard	- 7	34.1				2. Data of Dea Januar	th	198999°	3.55 A
Examin		4a. Facility Neme (If not institution, giv Doctors * Communi	ty Hospit	al			4b. City, Town, or L Lanham	ocation of Deeth	4c. County Prin	of Death	rge's
Funeral Director			Sex 7. A	lige (In yrs. last i		f Undar 1 Year Nonths Days	ff Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day Jan. 18	Year) 3, 1918	9. Birthplac Country, Pennsy	a (Stata or Foraig) ylvania
Maryiano a-f show	tor	Usual Rasidence of Dacedant 10a. Stete 10b. County Maryland Prince	George's	10c. City, To		ion				10d.	Insida City Limit
23a or 28	ral Direc	10e. Street and Number 6302 Homesteake		1 DOWIC		10f. Zip Coda 2072	0	1	Og. Citizan of V	What Country	
/z hours ener death with the Maryland natural', or items 23a or 28a-f show dical Examiner rount be notified at	by Funeral Director	11. Maritel Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forcas 1537 as 2 In Yas, Giva Year or Datas	? No /1_7		s Decedant of I as, specify Cub Yas 2 No	Hispanic Orlgin? (Sp an, Maxican, Puarto Specify:	ecify Yas or No- Rican, etc.)	Bia	ce - Amarican ck, Whita, atc	
than .	Completed	15. Decadent's Ec (Specify only highest gra Elamentery/Secondery (0-12) 12	ducation ada complated) Coilaga (1-4or 5+	5+)	Sa. Decedant (Giva kin lifa. DO		pation during most of work d)	ing	United Navy	usinass/Indus d State	
n and Mantel Hygis Is marked other raumatic event, II	To Be C	17. Fathar's Name (First, Middla, Last) Joseph L. Greele 19e. Informant's Name/Reletionship (у				Ella C	Mothar's Nama (First, Middla, Meidan Surnama) Ella Carey Number or Rural Routa Number, City or Town, Steta, Zip C			
of Heelth end of Rem 27 Is n r other traur	19 20 20 20	Patricia A. Coll: 20a. Mathod of Disposition Burial 2 Cremation 3 C	ins Daug	hter	6302 F	lomeste	ake Place	Bowie M			
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bchec	y Physician/Me	Pert II. Other significant conditions of	ontributing to death	but not rasulting	in tha unde	rlying causa gi	van in Part I.	23b. Díd to		ntributa to th	e cause of deat
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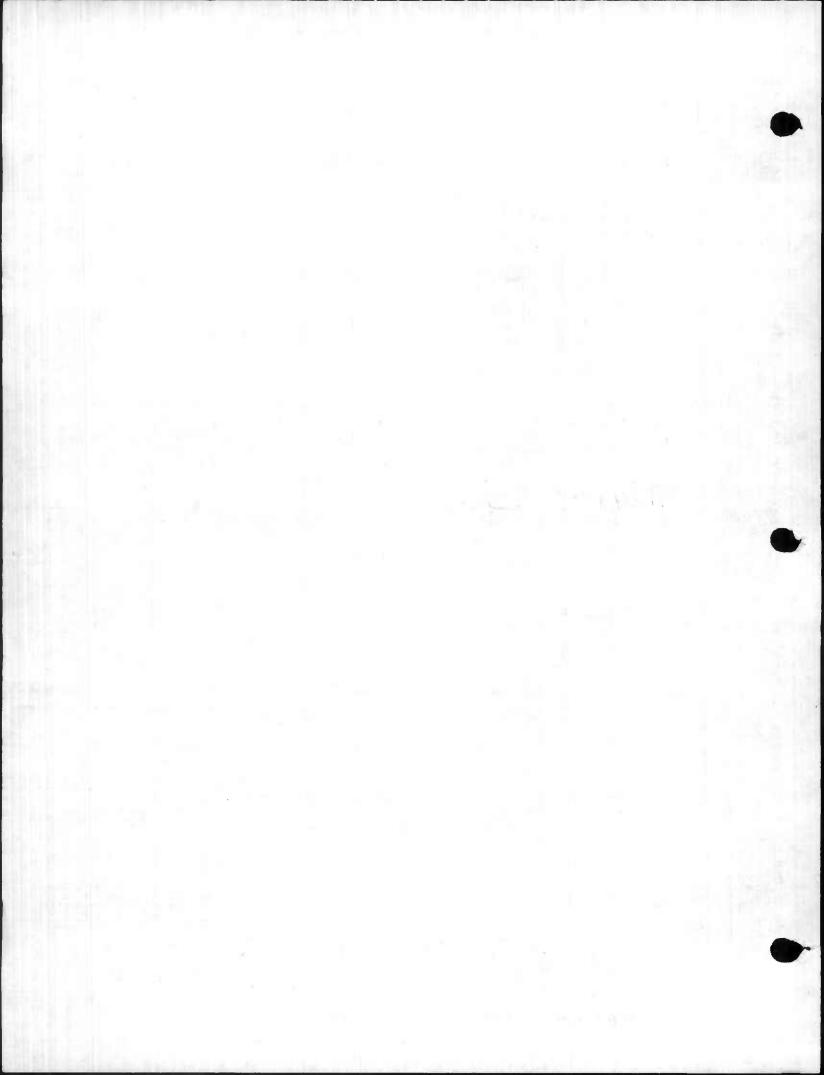
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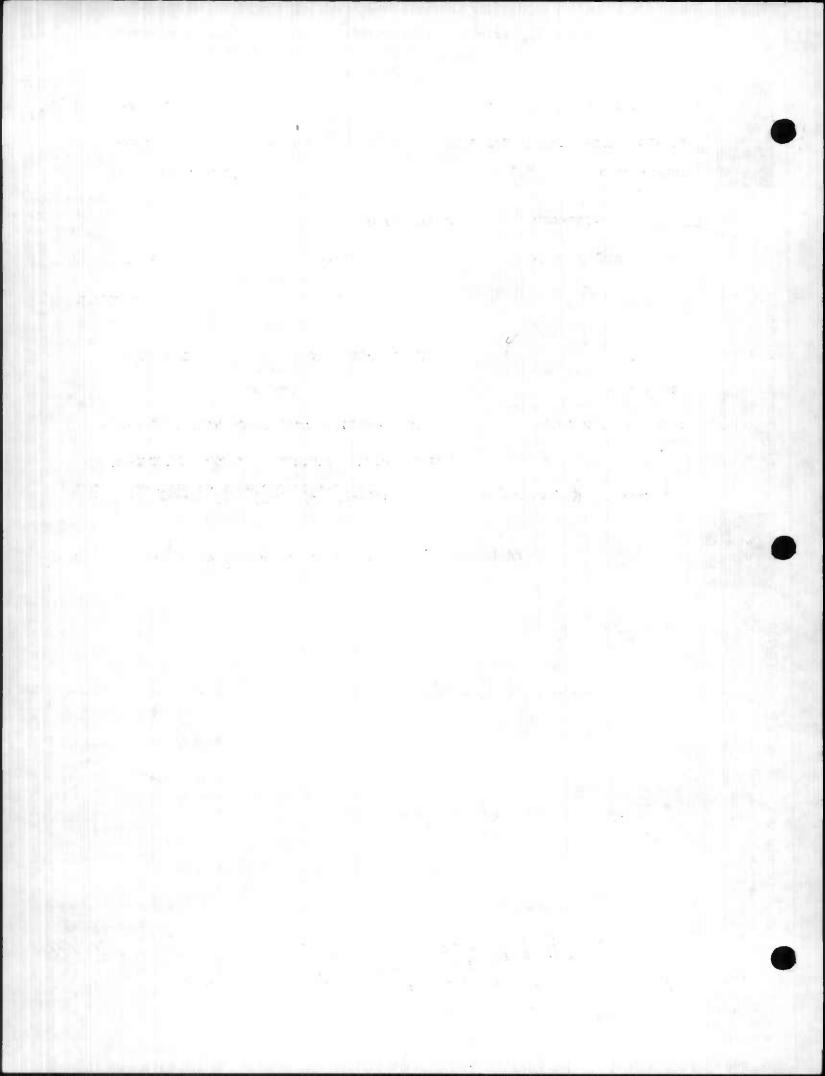
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Director	10e. Sfreet and Number			10f. Zip	Code		100 Citizen o	of What Country?		
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o Be	25. Was case referred to medical axaminer?	Hospitel:	2 ER/Out	patient 3 DO	OA Other: 45 Nu	rsing Home 5 Re	lome 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred			
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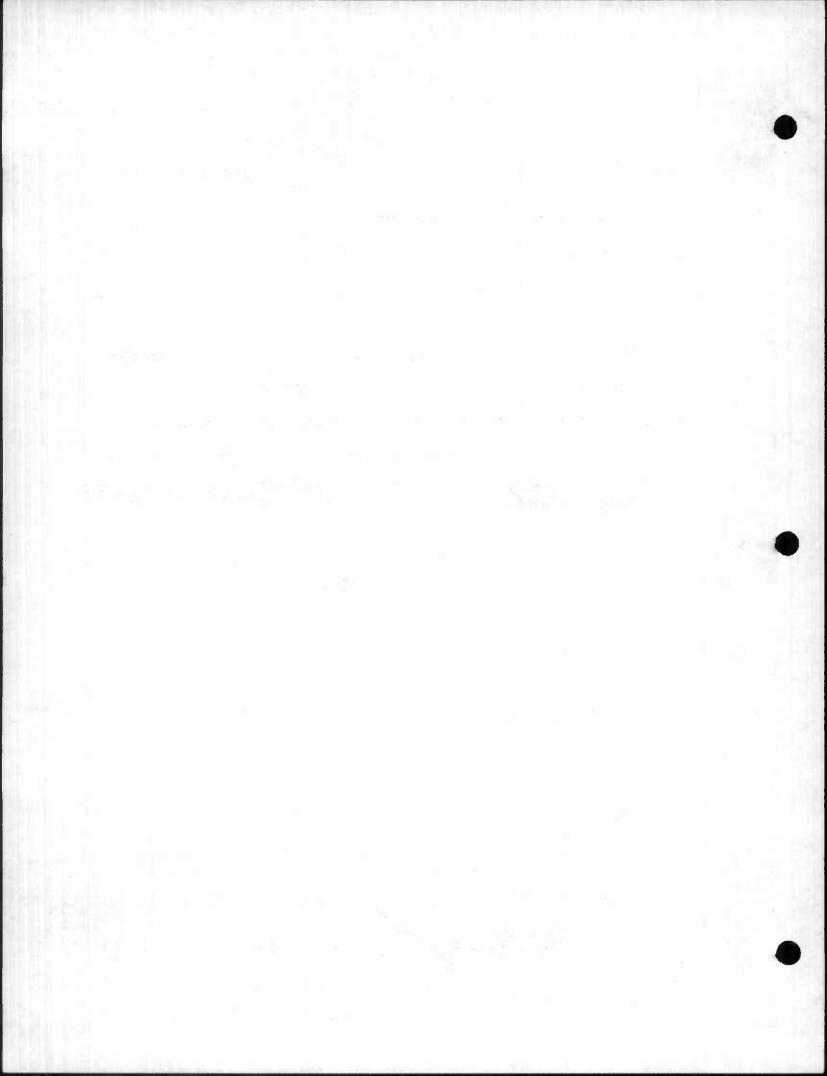
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/Medical Examiner	4e Facility Neme (If not instit	ution, giv	e street and nu	m <i>ber</i>)				4b. City, Tov	vn, or Lo	cation of Deet	h J 4c. Co	ounty of Death		1
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at ta	2 ☐ Accident inv	estigation				М	1	Yes 2 🗆	No					
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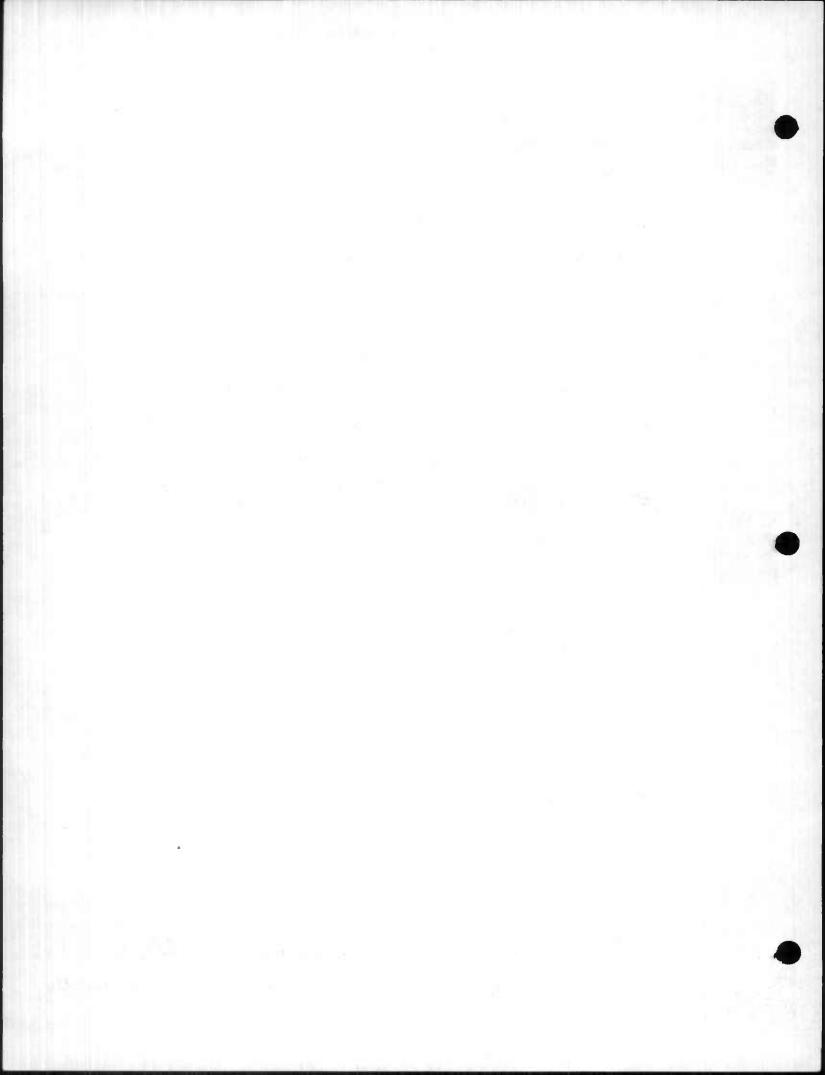
State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey Veer **Physician** MARIAN GARDNER 8:40AM 31, 1999 4c. County of Death /Medical JANUARY 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** NURSING LORIEN HOME COLUMBIA HOWARD If Under 1 Year Months Days 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 M 2 XF 73 Yrs 213-20-5383 Director 11/09/1925 PA Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Herma 29a any Injury or other traumatic event, the Medical Experimental ADGS. 11 STARWAY CT. 21228 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE SIERER 2 ANNA ROW 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ELWOOD "LEFTY" GARDNER/HUSBAND 1100 STARWAY CT. CATONSVILLE, MD 21228 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete N Burlel 2 ☐ Cremetion 3 ☐ Removal from State WOODLAWN CEMETERY 2/4/99 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. tul 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete **Physiclan** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) alzheimer Examiner Due to (or es e consequence of): Examiner wie dusion Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) physician s the burial P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 40 US8 signed by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Hypertenseon Division of Vital Records. þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed Deed hes page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 12. Naturel 2. Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 C Homicide 24 hours a 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme end eddress of person who completed cause of death (4.2.... 23a) (Type, Print) North Dr. Columbia Ho-Lai .Teng wo Knoll -6 31. Dete filed (Month, Day, Yeer) 32. Registra's Signeture State 4 1999 FEB Registrar



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Item 10c Per A.B. FilmG768 2-4-99 rja Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** Willa Dene Haefner 26, January 1999 2:45 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges # Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept. 30, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) Hours 245-20-4304 1 □ M 2 ☑ F 74 Yrs. 1924 North Carolina Director Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits show rai', or items 23s or 28s-f shores and Examiner must be notified at Maryland Prince Georges Sheltenham-Chel tenham 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10506 Barnsdale Drive 20623 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, pemit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental thyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinat page. Black, White, etc. 1 Navar Married 2 Married 1 ☐ Yas 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Davis Boston Poland Etta Dunkin Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Haslup/daughter 10506 Barnsdale Drive, Cheltenham, Maryland 20623 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Fungary Service Licenses Ronald S 22. Name and Address of Fecility
State Anatomy Board, 655 W. Baltimore Street Wade Director Baltimore, Maryland 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** OBSTRUCTIVE LUKE DISEAS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) 980 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, by The law requires 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed' has page 1 ☐Yes 2 ☐ No 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient edical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of Division or Attending Natural 2 Accident 5 Pending Investigation To the Hospital or Attenditional within 24 hours after death.
To the Funeral Director: A completely filled in by the formatter of the formatte death. 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month. Day, Year) 29b. Signatura and fitte of certifian 29c. License number 30. Name and address of person completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 4 1999

32. Registrar's Signature

The A. A. A. C. of

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or flams 23s or 28s-f show traumatic event, the Medical Examiner must be nuttined at

with the Maryland

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **JANUARY** 29. 1999 1611 PM 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deal 2710 W. FRANKLIN STREET BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign (Dountry) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Months Days Hours -58-9893 8 1 □ M 2 🕱 F Yrs 2,1951 Usual Residence of Decedent 10a. State 10b. Count 10d. tnside City Limits 1 XYes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? de Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status Biack, White, etc. 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry Eiemantary/Secondary (0-12) Collega (1-4or 5+) OX 17. Father's Name (First, Middle, Last) ner's Nama (First, Middle, Meiden Sumeme) 19a. Informant's Name/Raiationship (Type, Print) Son) 19b. Mailing Addrass (Street and Number gr Rurel Route Number, City or Town, Stete, Zip Code) Placa of Disposition Date 20c. Location - City or 20a Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Othar (Specify) 3 Ramovai trom Stata 21. Signature of Funeral Service 22. Name and Address of Facility 5 uneral Balto. Md. 2121 w. North Ave enter the disease, or complications that caused the death. or heart taylure. List only one cause on each line. Approximata interval Between Onset and Death Do not entar the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition rasulting in daath) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last Due to (or as a consequenca ot): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes 2 | No 24b. Wera autopsy tindings available prior to completion of cause of daath? 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician/Medical Examiner by

pege 2 s certificate hes Physicien: After this the funeral deeth.

Completed Be 10 Certification:

P.O. Box 68760. Division of Vital Records, Hospital or Attending efter deeth Director: filled in by 24 hours completely within 2 To the

> State Registrar

29b. Signatura and titia of certifier 30. Name and addrass of person who complated causa of da (b/(itam 23a) (Type, Print) THEODOREM. KIN

1999

5 Pending investigation

6 Could not be detarmined

25. Was case reterred to medical examiner?

1 Yes 2 No

27. Manner of Death 1 DNatural

2 Accidant

3 Suicide

29a. Certifiar

edicai

4 Homicide

(Check only one)

31. Date tiled (Month, Dey, Year)

1 Certifying Physictan: To the best of my knowledge, death occurred at the time, date and placa, and due to the causa(s) and mannar as statad.

Widedical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29c. License number

28c. Injury at Work?

1 Yes

2 No

3□ DOA

OCME

26. Piace of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) JANUARY 30, 1999

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Inpatient

28a. Date of Injury (Month, Dey Year)

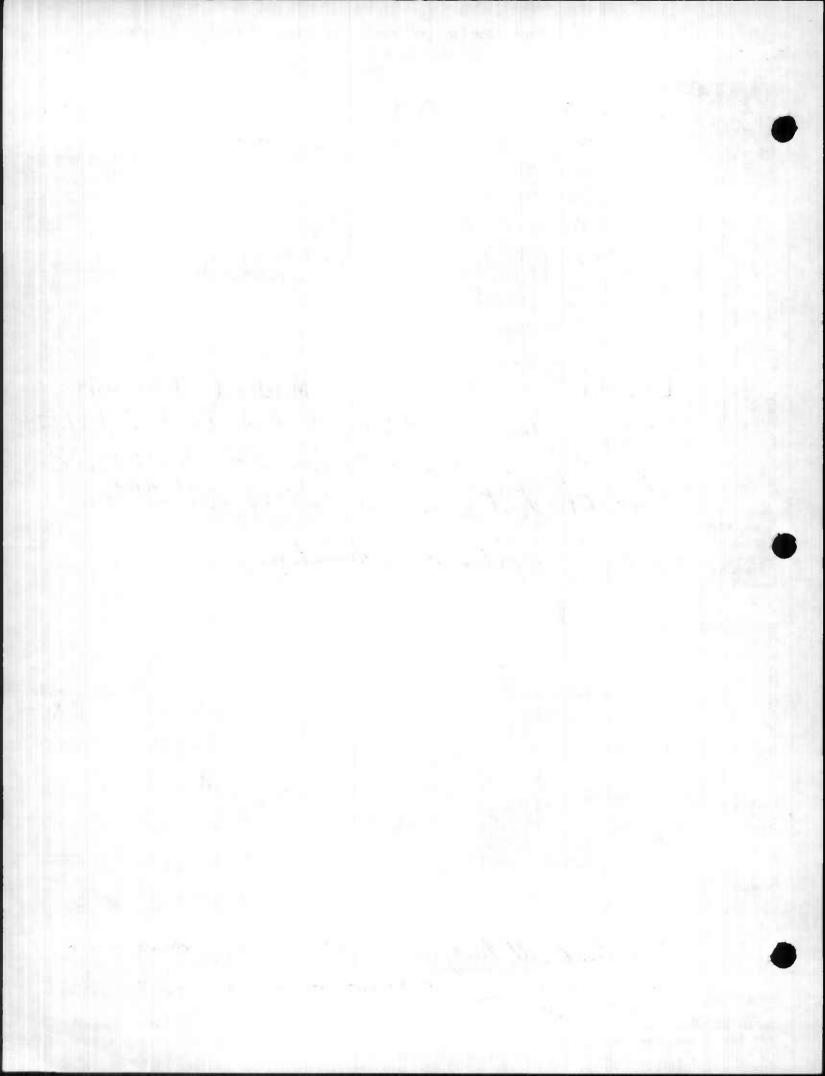
111 Penn Street, Baltimore, Maryland 21201

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28b. Time of

32: Riigistrar's Signature



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 Month **Physician** Robert Baumgarnier Hill Feb. 1 8:00 P.M. /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Prince George's Hospital Cheverly Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** NM 2□ F Months Days 430 56 4818 63 Yrs. July 7, 1935 Arkansas Director Usuel Residence of Decedent with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If them 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, in a Medical Exercise must be notified and Dece. XX Yes 2 No Directo Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12105 Lyden Lane 20715 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien Biack, White, etc. 1 Yes X No If Yes, Give Year or Dates: 1 Never Married 25 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Chemical Manufacture 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent'a Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Association 12 Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Thomas Hill Wilsie Baumgarnier 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William C. Hill, II Son 2 Old Weston Rd. Wayland MA 01778 20a. Method of Disposition

1 Buriai 2 Cremation 3 Removal from State 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) Old Bellwood Cemetery Feb. 6,1999 Pine Bluff Arkansas 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licanses Robert E. Evans Funeral Home, Inc. 23a. Pan Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appropriate the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

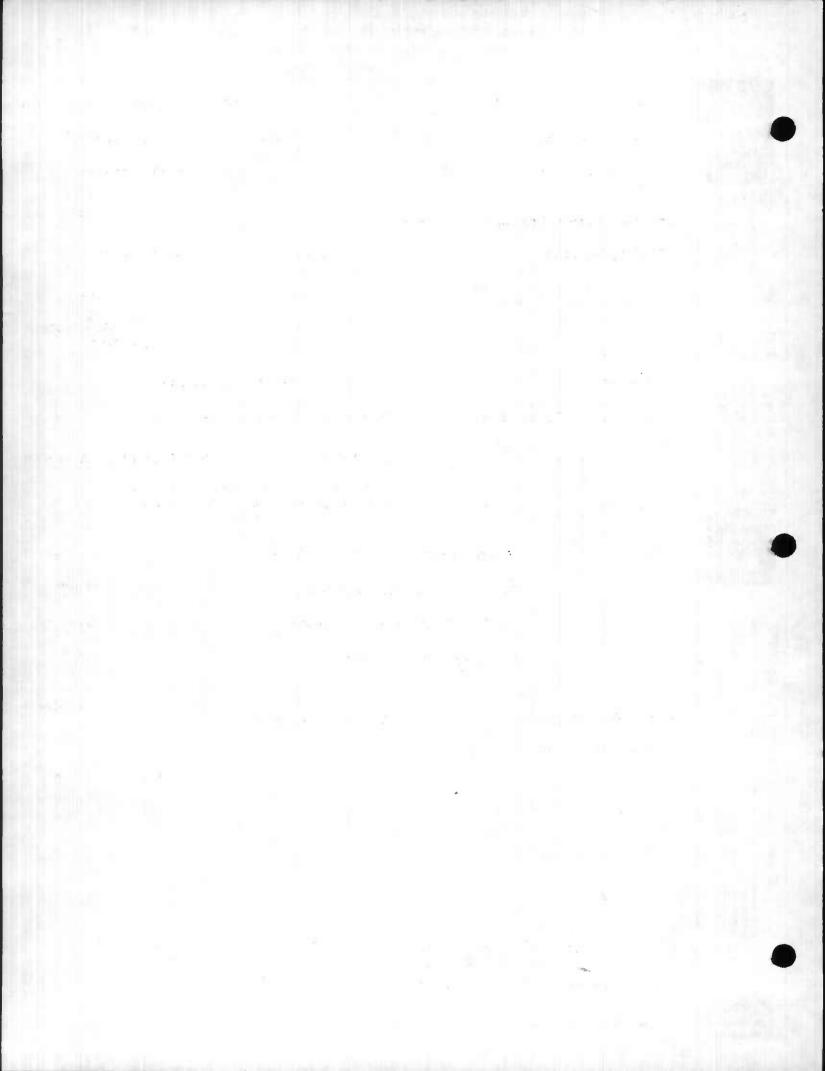
Appropriate the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appropriate the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appropriate the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finel Acute ventricular fibrillation disease or condition resulting in death) Minutes Examine Due to (or es e consequence of) Examiner minutes Acute myocardial rupture The law requires that the death certificate be axecuted ettending physician and for use as the buriel-transit Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute myocardial interction Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): years Coronary atherosderosis signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown acute renal failure hematoma, ò 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed hypertension 1 Yes 2 No 1 Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 1 No 28a. Date of tnjury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending 1 Yes 2 No n 24 hours after death.

Ne Funeral Director: Alphately filled in by the fu death. investigation 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of coulde dustag mp D24720 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravinder K. Rustagi, M.D. Cheverly, Maryland 20185 Road 6132 Landover 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar FEB 0 4 1999



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JAN. 31, 1999

CLIFTON HE	CNLEY		State of Ma	aryland / I	Departmer <i>Certificat</i>		lealth and M <i>Death</i>		giene 9 Reg. No.	02	852
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Physician · /Medical	Clifto	n Ty	rone	Henle	У			JAN.	30, 19		5:36 AN
Examiner	4a Facility Neme (If no	t institution, give	street end number)				4b. City, Town, or Li	ocation of Death	4c. County		
	JOHNS 1	HOPKINS	HOSPITAL	E.R.			BALTIMO	RE		NA	
Funeral Director	5. Social Security Number 214-80-1			a (In yrs. last bi 37	Yrs. If Under	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da 11-2		9. Birthpl Count	aca (Stata or Foreig Iry)
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should be filled within 72 hours after death with the Manyland of Mental Hyglene. marked other than "natural", or items 23s or 28s-f show unrafte event, the Madical Examinet must be notified at To Be Completed by Funeral Director	11. Marital Status 1 ☑ Never Married 3 ☐ Widowed 4 ☐		12. Was Decedent Armed Forces? 1 Yes 2 11 If Yas, Give		13. Was Dace If Yas, spe		Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yas or No- p Rican, etc.) 14. Rece - Ame Black, Whit		ck, White,	atc.
ural'	3 Widowed 4 Specify of		Yaer or Dates:			10					
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han han	Specify Elementery/Second 10th Gra 17. Father's Name (File 17. Father's Name (File 18. Specify 19. Spec	ry (0-12)	College (1-4or 5	i+)	Laborer		u)		McDonald's Re		
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The law ste hes page 2								1/2	Yes 2 No	1€	Yes 2 No
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his cer il direc	axaminer? 1 X Yes 2 □ No		Hospital:	ent 200XER/O	utpatient 3 D	DA Oti	har		dence 8 Oth	ner (Specifi	/)
Attending Physician: The is of death. ector: After this certificate he by the funeral director, page lifection: To Be Com	27. Manner of Death 1 Maturel 5 2 Accident	Pending Investigation	28e. Date of inju (Month, De	ry y Year) 28b.	Time of Injury M	28c. Inju Wo			how injury occur		
745 C		Could not be determined	28e. Placa of Inj building, et	ury - At home, f. c. (Specify)	arm, street, factor	y, office		28f. Location (City or To		ber or Rura	l Routa Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exam	sician: To the best of the basis of and manner of	examination at	e, death occurred nd/or Investigation	at the ti	me, date and place, opinion, death occur	end due to the red at the time,	cause(s) and middle and piece,	anner as si and due to	eted. the cause(s)
Within To the comp	29b. Signature and title	of certifier	14/		29	c. Licens	se number		29d. Data signe	d (Month,	Dey, Year)

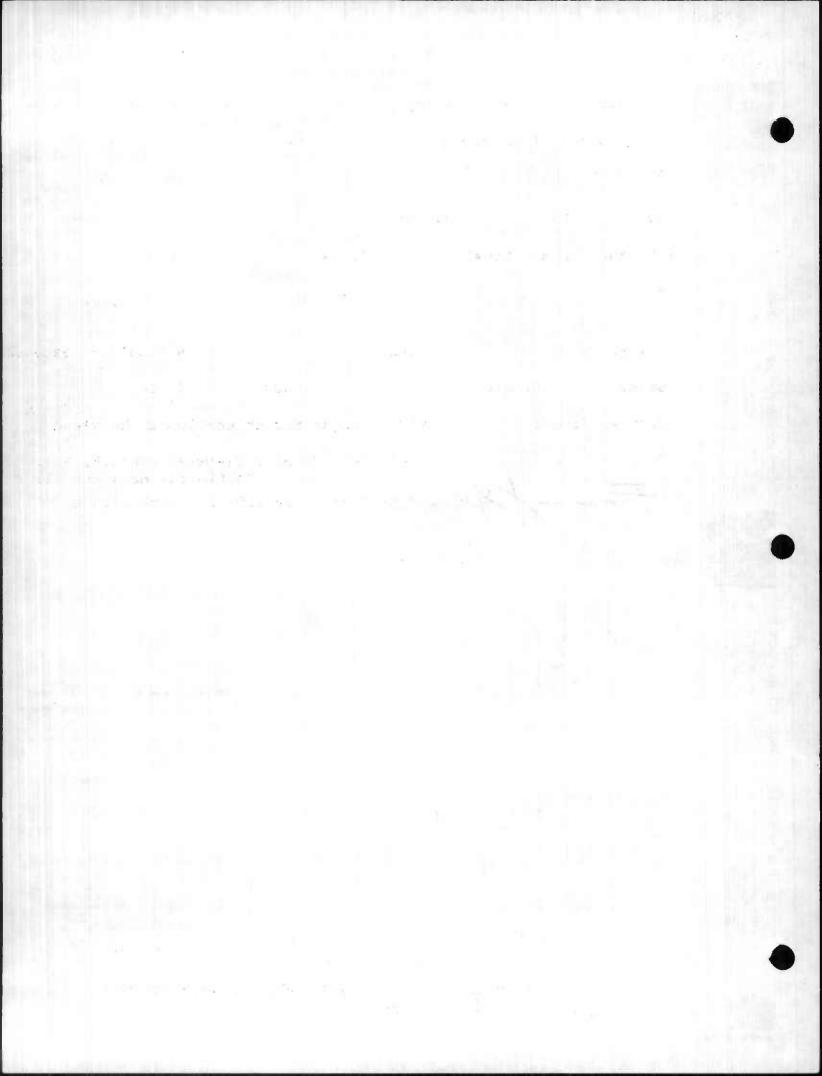
State Registrar

31. Date filed (Month, Dey, Year)

FEB 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

O.C.M.E



Piease Type or Print in Biack Indelibie ink. Assure Aii Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 31 3. Time of Death Month **Physician** MARY LOUISE JONES JANUARY 2.05 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death **Examiner** STELLA MARIS AT MERCY BALTIMORE If Under 24 Hrs. 8. 0 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10M 20F Months Days Hours Min. 51 Yrs. Director 6-14-47 218-46-8911 MD Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. fnside City Limits rail, or items 23s or 28s-f show Examiner must be notified at XXYes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4515 NORTHWOOD DR. 21239 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Biack, Whita, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or item 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12--0-PERSONNEL SOCIAL SECURITY 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Meiden Sumame) Pages 1 and 2 should be finant of Hasith and Mental ! JAMES MORRIS CINA HUGHES 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JOANN JONES (DAUGHTER) 4515 NORTHWOOD DR. BALTIMORE, MD 21239 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 2-6-99 BALTIMORE, MD 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funerei Service Licenses CFSA 1721-27 N. MONROE ST. BALTIMORE, MD 21217 Declo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) 980 Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings svailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 2 DXN0 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Plece of Deeth (Check only one) STE / A MARIS AT MERC Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) #05picE 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Neturaf 5 Pending Investigation n 24 hours after death.

The Funeral Director: After the funeral in by the funeral control of the funeral control 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral Di *Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40854 2/1/49 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Rusebers, Carl Pl Briting, MD ZIZUZ Source MA 301 12 31. Date filed (Month, Day, Year) 32 Bedistrar's Signeture State

DHMH 16 Rev 6/95

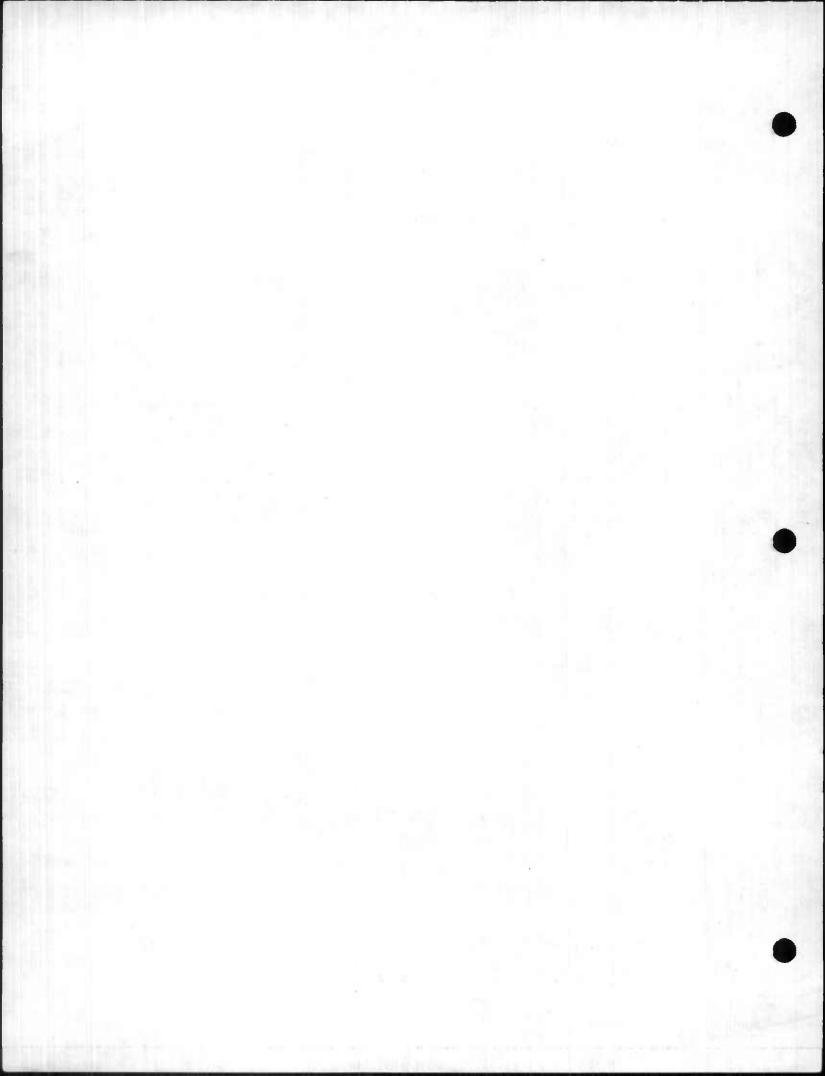
Registrar

Box 68760,

Records. P.O.

of Vital

Division or Attending



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 3. Time of Death Day JONES **Physician** FEBRUARY 3, 1999 01:10 A /Medical City, Town, or Location of Death **Examiner** BALTIM If Undar 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2 F Yrs. **Director** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo 10g. Cilizen of What Country? 10e. Street and Number ddg Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 M Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Baca - American Indian 11. Marital Status Biack, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed w Department of Heelth and Mentai Hygien Important: If Itam 27 ie marked other th eny Injury or other treumetic event, the 18. Mother's Name (First, Middle, Maiden Sumama) 17. Rather's Name (First, Middle, Last) To Be 20a. Method of Disposition 1 Burlal 2 Cremation 3 Ramoval from State 4 Donation 8 Other (Specify) use of complications that caused the death. Do not enter the mode Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical ASCU Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nyper ension Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☑ Chknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 2/2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one)

29d. Date signed (Month, Day, Year)

February

B H5876113

Avenue,

Baltimore, MO

NAME Nathaniel Jones

Division of Vital Records, P.O. Box 68760,

Registrar DHMH 16 Rsv 6/95

State

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death

filed within 72 hours efter

al Hygiene.

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page 2 should

certificate hes

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director,

29b. Signature and title of certifier

31. Date filed (Month, Day, Ver)

Michelle Hengseler

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

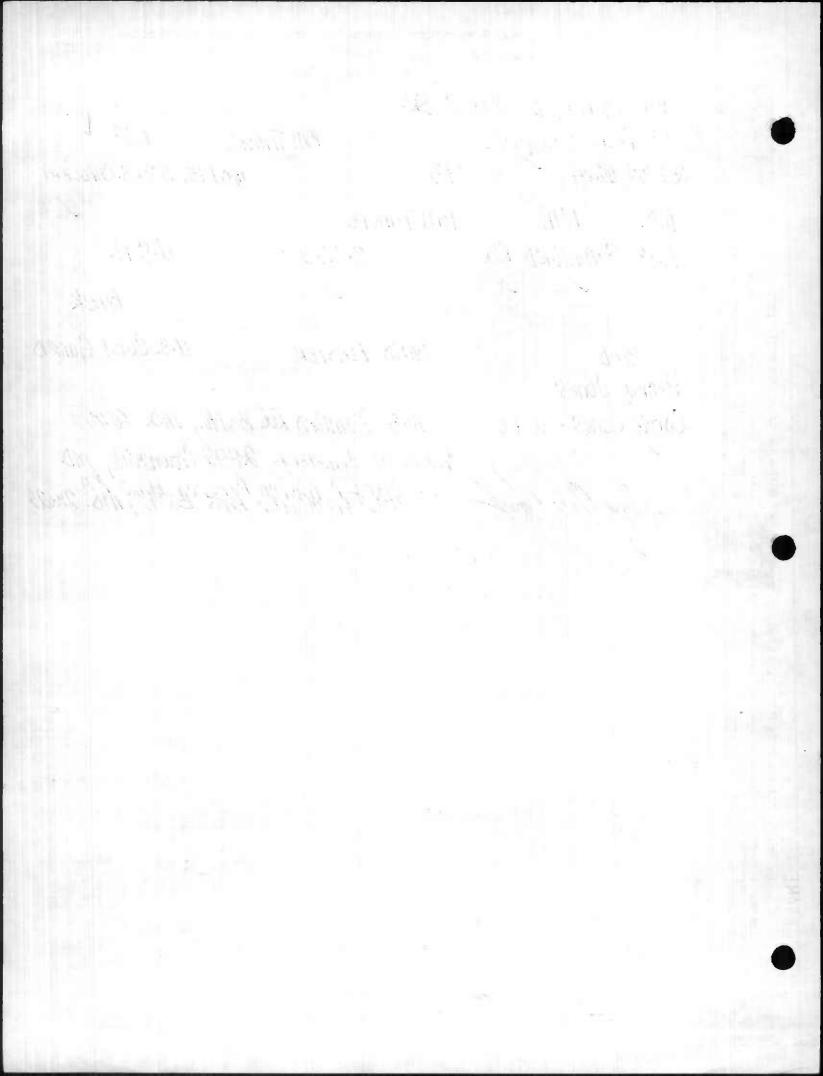
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900 caton

32. Heastrer's Signature

altimore, Maryland 21215-0020

ir than "naturel", or itema 23a or 28a-f ahow the Medical Examiner must be notified at



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 0 2 8 5 5

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Examiner	4-	Facility Name (If not in:	stitution, gi	ve street end nu	umber)				4	b. City, To	wn, or Lo	cation of Dea	h 4c. Count	y of Death	
		Church Ho	ome F	Hospita	al					Balt	imo	re	NA	A	
Funeral		Social Security Number	6.	Sex		n yrs. last bir	thday)	If Under 1		If Under			rth Vacal	9. Birthp	placa (Stata or For
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DHMH 16 Ray 6/95

ORIGINAL

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			Decedent's Nama (First, Midd)				tificate of	Death	F	Reg. No.		2000	
п	Physic	ian							2. Date of Des Month	Day	Year	3. Tima of Death	
	/Medi		Alberta Jor 4a. Facility Name (If not institution		or!			4b. City, Town, or	Februa		999	4:25AM	
ч	Exami	ner	Mercy Med		91)			Baltim			or Death		
Н	Funeral		5. Social Security Number		Age (In vrs.	. last birthday)	If Undar 1 Year			NA	9 Ridhr	alana (State or Foreign	
	Funeral Director		224-30-3928 Usual Residence of Decedent	1□ M 2√1 F	76	Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Da) 10-24			place (State or Foreign ntry)	
	/land		10a. State 10b. County			ty, Town or Loc					1	Od. Inside City Limits	
	Man Man	ţ	MD N	A	Ba.	ltimor	е					X□XYes 2□No	
	or 28	Director	10e. Street and Number				10f. Zip Code			l0g. Citizen of V	Vhat Cour	ntry?	
	th wi	<u>a</u>	1900 E. La	fayette A	venue	Э	2121	.3		USA			
120	72 hours after death with the Maryland "natural", or frams 23a or 28a-f show actived Examinating the notified at	by Funeral	11. Marital Status 1 □ Nevar Married ≱ Mar 3 □ Widowed 4 □ Divorced	If Yes Give	s? ≛No	11	as Dacedant of H Yes, specify Cub ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yas or No- o Rican, etc.)	14. Race Biac Specify	k, White,		
9	tura Fer E	8		nt's Education	5.	16a Decede	nt's Usual Occur	netion		16b. Kind of Bu			
215	5 . 3	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed)	. F. \	(Giva ki	ind of work done O NOT use retire	eatlon during most of word)	rking			State	
21		mo:	10th Grade	College (1-4e	or 5+)		ekeepir				pita		
Maryland 21215-0020	0 7 0 5	Bec	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	ne (First, Middle,	Maiden Surnam	0)		
yla	should be ind Mental marked c	To	Garfield	Baker				Nellie	9	Youn	g		
lar	end end s m		19a. Informant's Name/Relations									Code) 21213	
	5 7 N F			ones				fayette	Avenue	Baltı	more	∍, MD.	
Baltimore,			20a. Method of Disposition 1 Buriai 2 □ Cramation 4 □ Donation 5 □ Other (S			Place of Disposi cematery, crema rbutus	atory or other plan	Gardens	02-06-	20c. Location - 99 Ar		own, Stata 18, MD	
Balt	permit. Pege: Department of important: If I any injury or once.		21. Signature of Fugeral Service	Licensee	-		Name and Addre	Ва			_	nd 21202	
			23a, Part1. Enter the disease, or	WM.C. March FH 1101 E. North Avenue 23a Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between									
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Sep5is Due to (or as a consequence of):										
-	D / E	ner			Re				1				
	pund inasit	Cam	Sequentially list conditions,	D	or as a conseque	ence of):							
60,	tificete be executed g physician and as the buriel-tragsit	edical Examiner	Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Disease or Injury that Initiated events							1			
68760,	ohysi the t	dice	that Initiated events resulting in death) Last	ence of):				1					
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P.O.	thet the death cer ed by the ettendir deteched for use	Physician/M	Part II. Other significent condition	larlying cause giv	en in Part I.				the cause of death?				
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Records,	been s	Completed b							24a. Was a perfor		av	are autopsy findings allable prior to mpletion of causa death?	
Re	he lav e hes age 2	Juo							1 🗆 Y	es 2 No		Yes 212 No	
ta	iclan: The certificate rector, pag	BeC	25. Was case referred to medical	1				26 Place of Des	th (Check only or		16	J Tes ZBENO	
of Vital	Physiclan: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	tient 2 🗆	ER/Outpatient	3□ DOA Oth	or	ome 5 ☐ Reside		r (Specifi	v)	
o uo	ath. : After th e funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	9		28b. Time of Injury	28c. Injur Wor		28d. Describe h				
Division	To the Hospital or Attending Physician: The Is within 24 hours effected beach. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could in determined		oma, farm, stree y)	t, factory, office		28f. Location (Si City or Town	reet and Number, State)	er or Rura	I Route Number,		
	Hospitu 24 hours Funera letely fille	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a second of the cause (s) and the cause (s) a								nner as st and due to	ated. the cause(s)		
	Vithin Vomp	Me	29b. Signature and title of certified	NATE AND DESCRIPTION			29c. Licens	e number	2	9d. Data signed	(Month,	Day, Year)	
			Igh	h	MD		P	12-511	1	5 b	2	1009	
	10		30. Name and address of person			n 23a) (Type, Pr			1	rebruari	1 2,	1771	
			John Wa			aul st		nore, M	D 212	>1			
	Sta		31. Date filed (Month, Day, Year)		stor's Signa	ture	· Asa					The state of the s	
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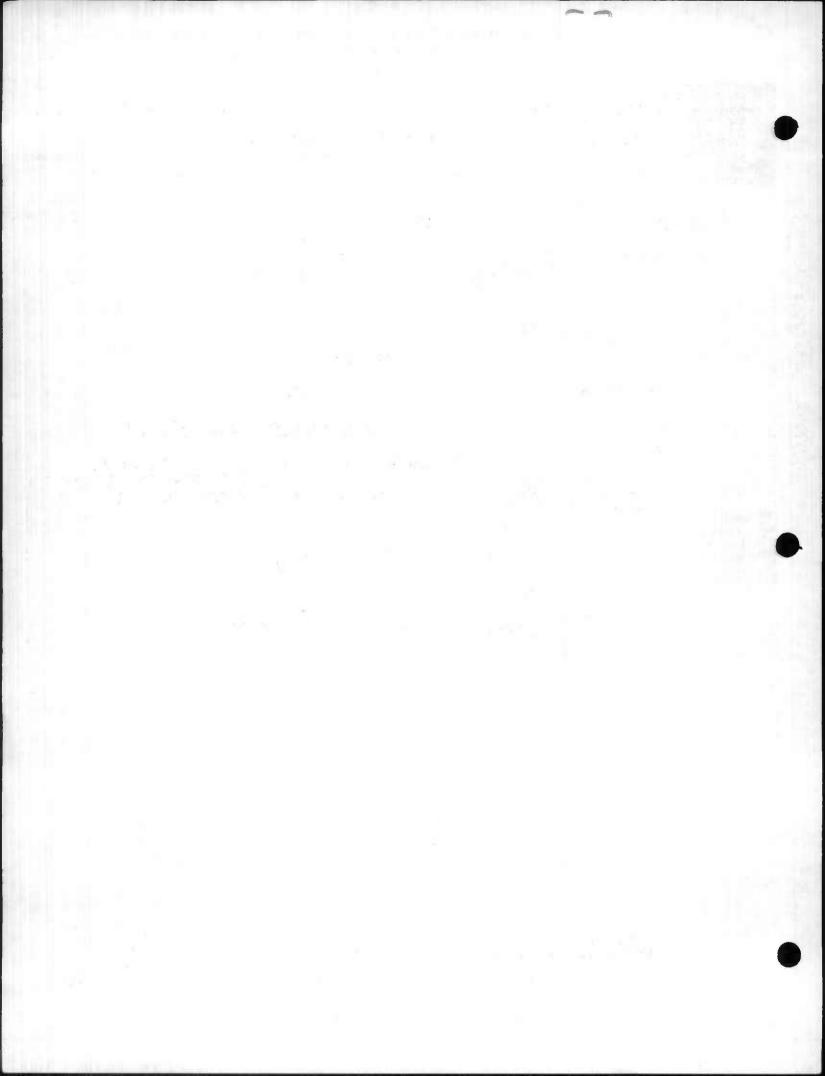
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January OLIVIA M. JACKSON /Medical 4b. City. Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore City Hospital maryland General If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** 1 M 3 F Yrs. Director 219-307356 90 10/05/08 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1☐YYes 2☐No Director BALTIMORE MD. 7 is marked other then "natural", or items 23s or 28s-f traumetic event, the Medical Examiner must be notified 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21201 U.S.A. Funeral 1100 PENN 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL PARKER 2 SARAH PARKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5215 WINDSOR MILLSRD.

20b. Place of Disposition (Name of cometery, crematory or other placa) 21207 BALTO MD.
Dete 20c. Location - City or Town, State CHRISTINA DILLARD 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) CALVARY CHURCH CEM. 2/6/99 ABERDEEN MD. 22. Name end Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 1300 EUTAW PALCE BALTIMORE MD 21217 23a. Part1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause of each line. Approximate Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Encephalopathy Examiner Examiner physician and s the buriei-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical signed by the ette Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Wiknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to Completed completion of cause of death? has 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: offer death. Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Inpatient 2 PER/Outpatient 3 DOA funeral 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours efter des To the Funeral Directo completely filled in by the 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Caryland General Hospital. 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Kanua 4 m.D. ehmina 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



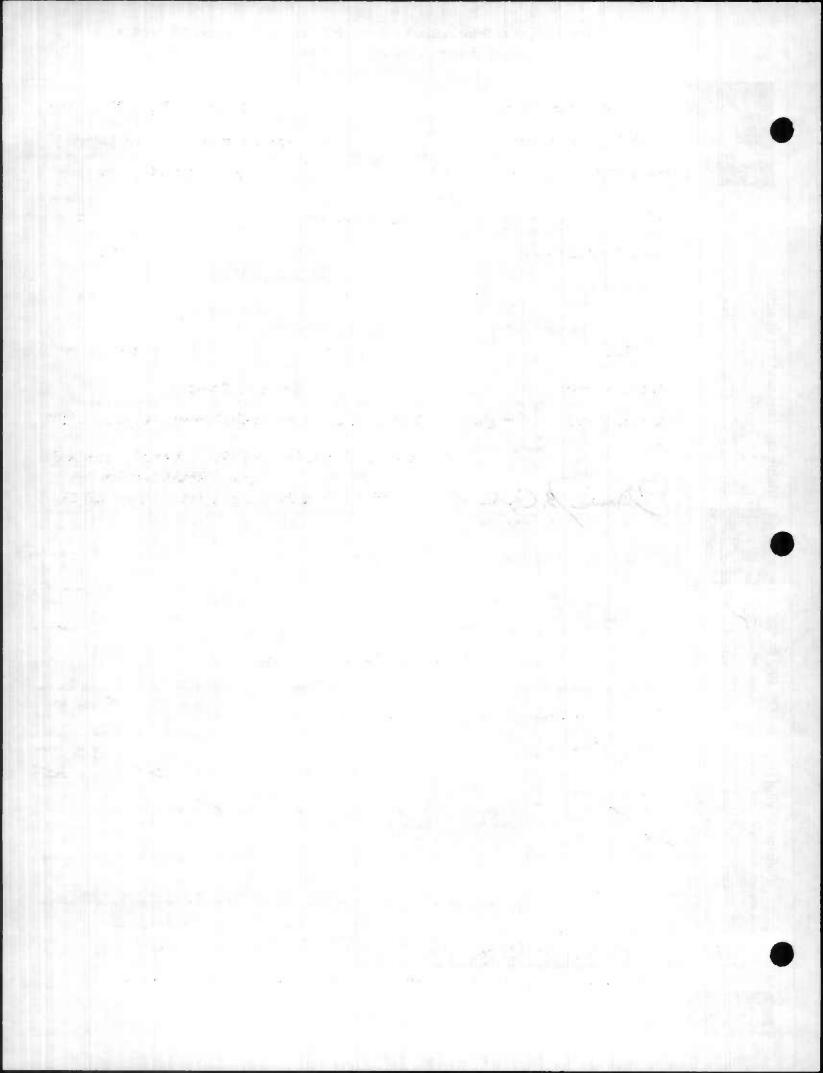
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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Edna Irene Johnson February 02, 1999 5:50am /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 3914 Carthage Road Randallstown Baltimore If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 6 Sex **Funeral** Months 1 M M TE Days 87 June 13,1911 **Director** 215-14-0870 Maryland Usual Residenca of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "naturel", or itema 23s or 28s-f show traumatic event, the Medical Examiner must be notified at ¥ Yes 2 No Director Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3914 Carthage Road 21133 TISA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filled within 72 hours after in and of Hatilh and Mental Hyglene.
nt: if item 27 is marked other than "naturel; or item yor other traumatic event, the Mental Examine my or other traumatic event, the Mental at Examine. 1 Yes 2 No 1 Never Married 2 Married Maryland 21215-0020 1 Yes TNo Specify: Specify: Black by 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Second 12th condary (0-12) College (1-4or 5+) Laborer Packing House 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Albert Wallace Isabelle Creek 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tnformant's Name/Relationship (Type, Print) (Daughter) 3914 Carthage Road Randallstown, Maryland 21133 Mary A. Jones Baltimore. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department of Important: if ony Injury or once. Maryland Nat'l Mem Pk 2/06/99 Laurel, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility Caple Funeral Service 21. Signature of Funerel Service Licensee 5502 Winner Avenue Baltimore, Maryland 21215 complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximete Intervat Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes an autopsy performed? Completed page 2 1 Yes 2 200 1 Yes No certificata or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 24 hours after death.
Funerel Director: After this etaly filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 1 Detatural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical completaly (Check only one) To the I within 2. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 3745 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) J. Kray, Dapt FM 29 S. Paca St. Boltimore, MD 2120 mo 31. Dete filed (Month, Ray, Year) 32: Registrar's Signeture State

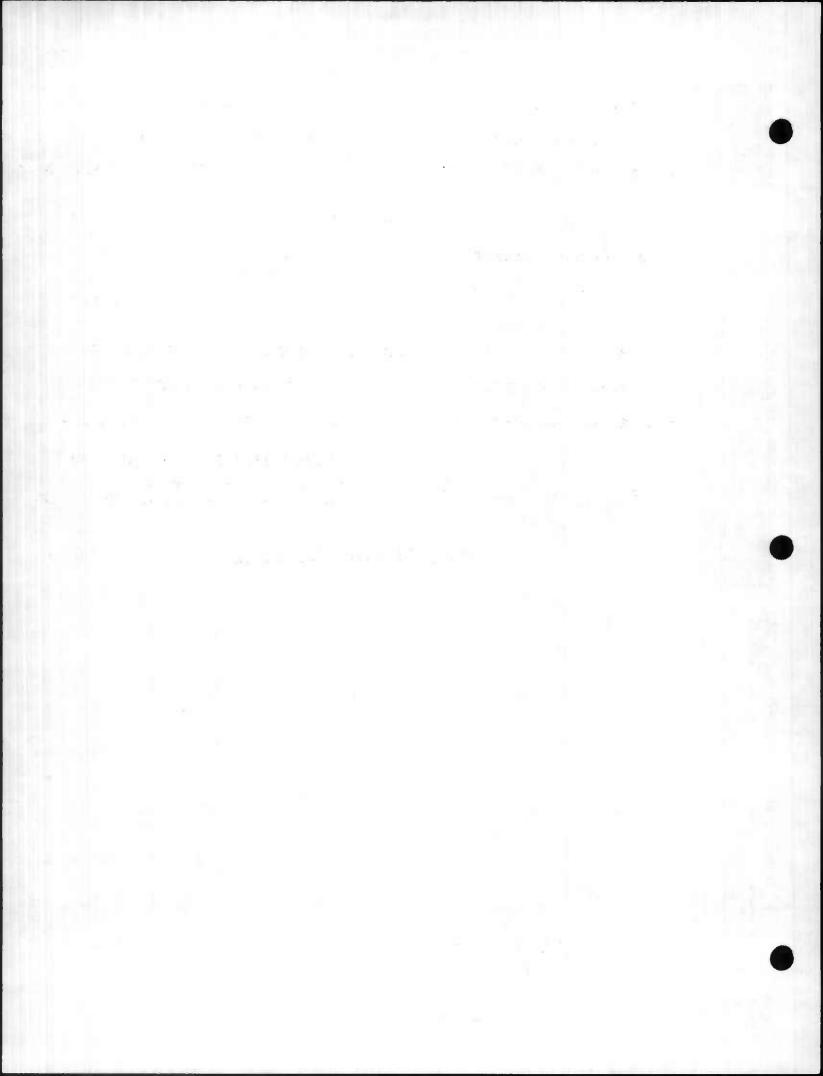
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) JANUARY 29, 1999 **Physician** VICTOR F. JANISHEFSKI 17:05 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, give street and number) **Examiner** BALTIMORE 323 FOLCROFT STREET If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5/21/10 5. Sociel Security Number 9. Birtholece (State or Foreign 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours PENNSYLVANIA 156 M 2□ F 177-12-2047 88 Yrs. Director Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limite r is marked other than "natural", or flems 23a or 28a-f show traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director N/A BALTIMORE MD 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 21224 U.S.A. 323 FOLCROFT STREET Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Merital Status pemit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mantal Hygiane. Important: If Itsm 27 is marked other than "natural", or the any Injury or other traumatic event, the Mantal East rine. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) BETH STEEL BATTERY CHARGER 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) MAGDELINE SLINSKI FRANK JANISHEFSKI 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 323 FOLCROFT ST. BALTIMORE, MD. 21224 MRS. STELLA JANISHEFSKI 20b. Place of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 ☐ Cremation 3 ☐ Removal from State 2/2/99 dundalk, MD. 4 ☐ Donation 5 ☐ Other (Specify) SACRED HRT.OF MARY 22. Name and Address of Facility KACZOROWSKI FUNERAL HOME P.A. 21. Signeture of Funerel Service Licenses 1201 DUNDALK AVE. BALTIMORE, MD. 21222 uge auto 23a. Part1. Enter the disease, or es pplications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to or es e consequence of) Physician/Medical Examiner the buriel-transit Sequentielly list conditions, if any, leading to Immediete cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence of) physician and Division of Vital Records, P.O. Box 68769, The law requires that the death certificate be Due to (or as a consequenca of): SBS 23b. Did tobacco use contribute to the cause of deeth? ed by the e Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed been s certificate has b lirector, page 2 s 1 Yes 20 No 1 ☐ Yes 2 ☐ No or Attending Physician; director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 8 □Other (Specify) this in 24 hours after deam.
The Funeral Director: After this funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manger of Deeth 28b Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital edicai 1 🖫 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) end manner as stated. 29a. Certifian (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. within 2 29b. Signature and title of cartified 29c. License number 29d. Dete signed (Month, Dey, Year) 0 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 6430 BAUTO. MD 2/222 Au HOLABIND 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature FEB 4 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Death 1 Decedent's Name (First, Middle Last) 1235 am rebruary Jones 4b, City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) maryland General Hospital Ltimore if Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplece (Stete or Foreign Country) 7. Age (In yrs. lest birthdey) Months Days Hours Min 1□M 20 F Yrs. 212-22-6371 74 M.D. 01 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 14. Raca - American Indian, 21229 601 North Augusta Ave 12. Wes Decedant Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bieck, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify Black 3 Widowed 4 □ Divorced 15. Dacedent's Education (Spacify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 9th grade 17. Fether's Neme (First, Middle, Last) Private Domestic Worker 18. Mother's Name (First, Middla, Maiden Sumeme) Paul R. Jones Maggie Baptist 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 601 North Augusta Ave, Baltimore Md 21229 Melvin Jones-Son 20c. Location - City or Town, State Date 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Othar (Specify) 2/5/99 Baltimore, Md Baltimore National 21. Signatura of Funerel Sarvice Licenses 22. Name end Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 23a. Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respirelory arrest, shock, or heart failure. List only one cause on each line. 21215 Approximate Interval Batween Onset and Death Immediate Cause (Final disease or condition resulting in death) HSDIRation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated evants rasulting In daath) Lest Due to (or as a consequence of) Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Miknown 24b. Were autopsy findings eveileble prior to completion of causa of deeth? 24a. Was an eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28d. Describe how Injury occurred

Physician/Medical Examiner thet the death certificete signed by the a þ Completed peed s The law certificate hes Physician: Be 10 After this funeral Certification: or Attending s after dea....al Director: After tv filled in by Hospital within 24 hours a edical completely

Physician

/Medical

Examiner

Funeral

Director

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Physician /Medical

Examiner

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Funeral

by

Completed

2

Box 68760. P.O. Records, Division of Vital

25. Was case referred to medical examinar? 1 Yes 2 No 27. Mannar of Death 1 Watural

5 Pending Invastigation 2 Accident 3 ☐ Sulcide 4 | Homicida

6 Could not be datamined

Data of Injury (Month, Dey Yeer)

28c. Injury at Work?

1 Yes 2 No 28a. Place of Injury - At home, ferm, streat, fectory, offica building, etc. (Specify)

281. Location (Street end Number or Rural Route Number, City or Town, Stata) 1 Destifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end mannar es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and the of certifier

29a. Certifier

(Check only one)

29c. License number

29d. Date signed (Month, Dey, Year)

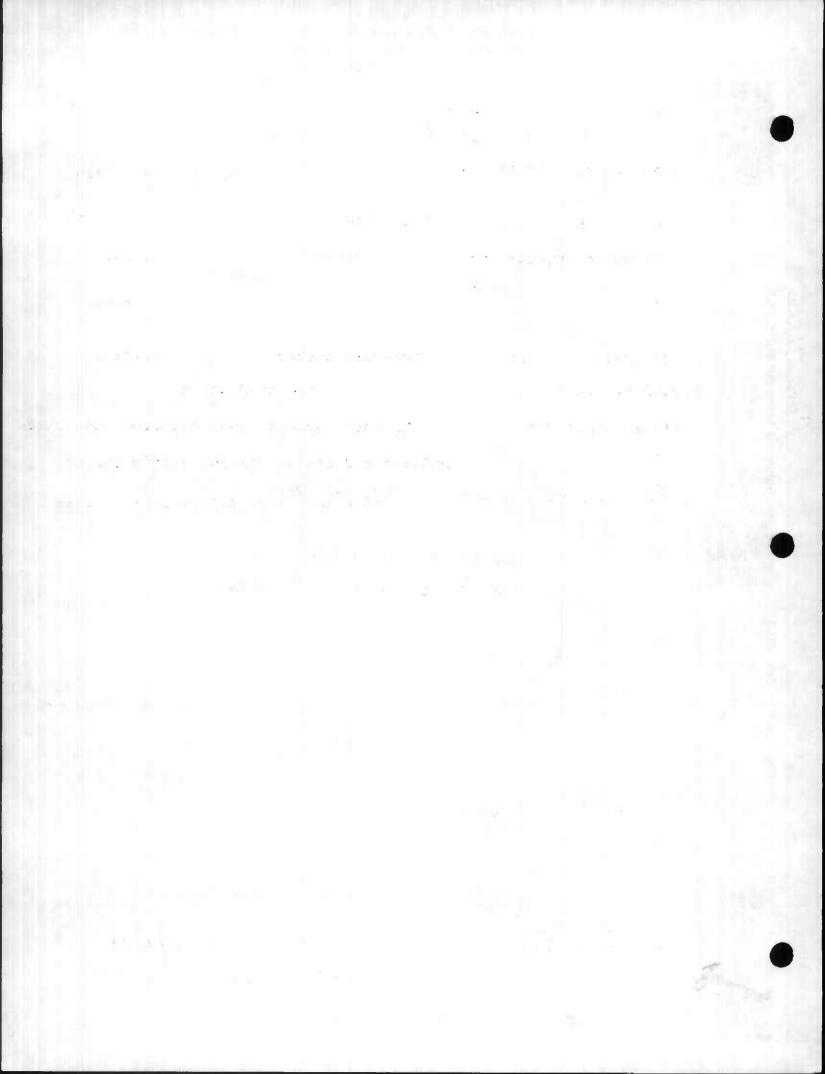
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Registrar

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print) And Sakante, M.D. 10 Mark 31. Dete filed (Month, Dey, Year)

32. Registrar's Signature 4 1999

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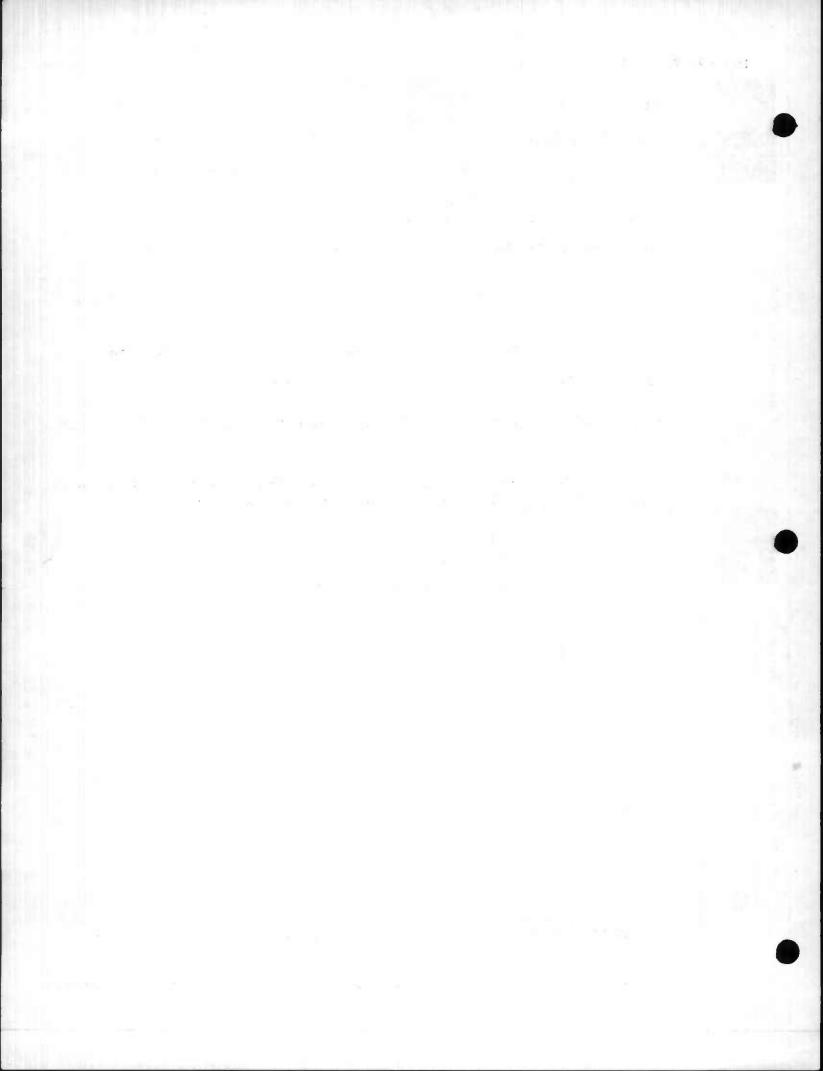


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Registrar

KNOP# MARIE

NAME:



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth 3 Time of Death 9:50Pm Katherine A. Koontz February 1999 4e. Fecility Nama (If not institution, give street end number) Charlestown Nursing Center 4b. City, Town, or Location of Death 4c. County of Death Catonsville Baltimore If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) March 24, 1914 5. Social Sacurity Number 024-05-6495 7. Aga (In yrs. iast birthday) Birthplaca (Stata or Foraign Country) Days 1 □ M 2 🖾 F Vrs 84 Mass Usual Rasidanca of Decedant 10b. County 10c. Cify, Town or Location 10d. fnsida City Limits Baltimore Catonsville 1 ☐ Yas 2 ☑ No 10f. Zip Coda 10g. Citizan of Whet Country? 715 Maiden Choice Lane U.S.A. 21228 12. Wes Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, Black White atc. Yas 2 No If Yas, Giva Yeer or Datas: 1 ☐ Navar Married 2 ☑ Marriad 1 ☐ Yas 2 ☐ No Specity: White 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working iifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Eiamentary/Secondary (0-12) Collaga (1-4or 5+) Data Processor Banking 17. Father's Nama (First, Middia, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Cornelius Sullivan Katherine Cusack 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Edward J. Koontz (Son) 9808 Bridle Brook Drive, Owings Mills, MD 21117 20b. Placa of Disposition (Nama of camatary, cramatory or other piaca) 20c. Location - City or Town, Stata 1 X Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata Garrison FOrest Veterans 2/8/99 Owings Millis, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Addrass of Fecility Witzke Funeral Homes, Inc. 21 Signature of Funaral Sarvice Licenses 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Entar the disease, or complications thet caused the deeth. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate intarval Between Onset end Death months Dua to (or as a consequence of) Dua to (or as a consaguanca of): Dua to (or as a consequance of): 23b. Dfd tobacco usa contribute to the cause of death?

Physician /Medical **Examiner**

is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit

Physician/Medicai

þ

Be Completed

Certification: To

Medical

The law requires that the death certificate be axecuted

Box 68760,

P.O.

Records,

of Vital

Division

Department of Health ar Important: If Item 27 is any Injury or other treu pace.

Physician

/Medical

Examiner

10a State

by Funeral Director

Completed

MD

10e. Street end Number

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0020

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated evants rasulting in daath) Last

Immediata Causa (Final disaasa or condition rasulting in daath)

20a. Mathod of Disposition

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION 24e. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death? ANEMIA CHP 1 Yas 2 No 1 ☐ Yas 2 🔀 No 25. Was casa rafarred to medical 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2X No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Certifiar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. Licensa number

29b. Signeture end title of certifier

D26473

29d. Dete signed (Month, Dey, Year) February 3, 1989

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

DERNARD F KOZ LOVS CY, MD 7/1 MAIDEN CHOICE LANE 21228

State Registrar

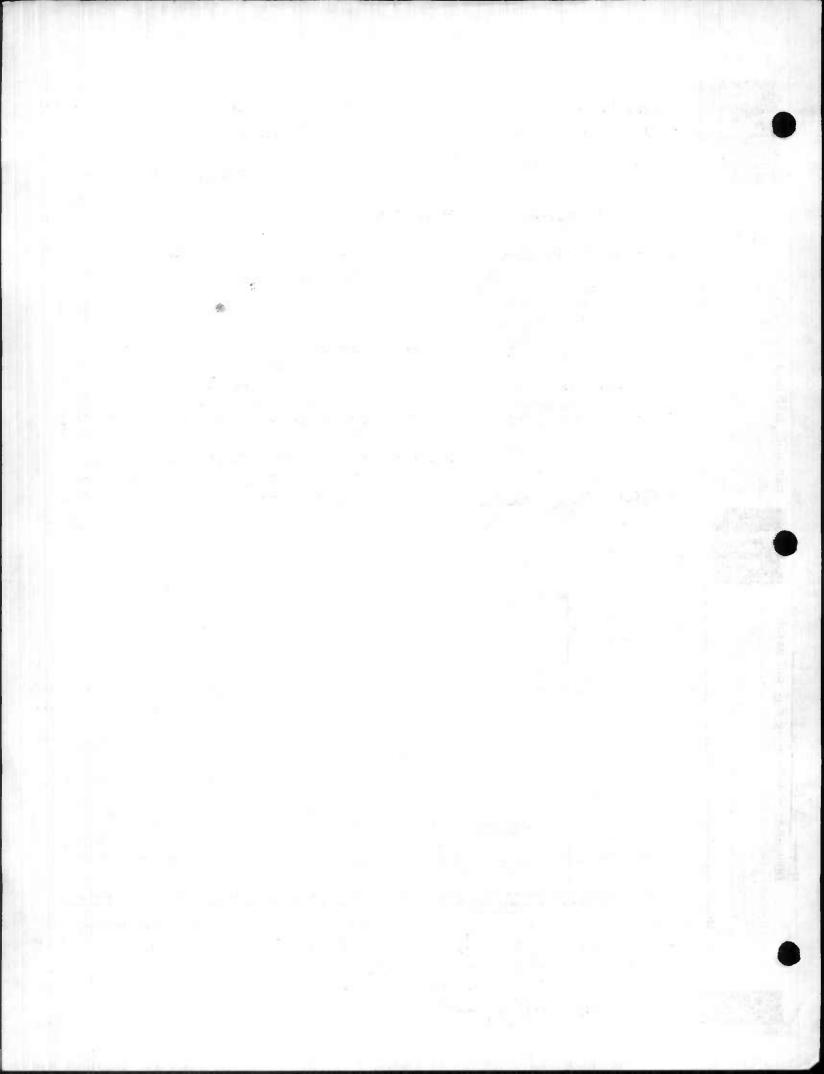
31. Data filed (Month, Day, Year)

4 1999



To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2



Physician

/Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

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Completed

Be

9

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

with the Maryland

death

72 hours after

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permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If item 27 is marked other?

Baltimore, Maryland 21215-0020

Examiner Physician/Medical p Completed Be 0

physician and s the bunal-transit executed Box 68760, that the death certificate be attending 0 signed by the at Id be datached fo o ے Records, The law requires peen has page certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completaly filled in by the funeral director,

State

Registrar

Immediate Cause (Final diseese or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Carensna of Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown in remission 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy 2 No 1 TYes 1 □ Yes 2 □ No 25. Was cese referred to medical 26. Place of Deeth (Check only one) exeminer? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Naturel 5 Pending Injury 1 Yes 2 No 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner as steted.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner steted. edical 29e. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b Signature and little g 29c. License number AHENDING

Melrose Are

31. Date filed (Month, Dey, Yeer) FEB n 4 1999

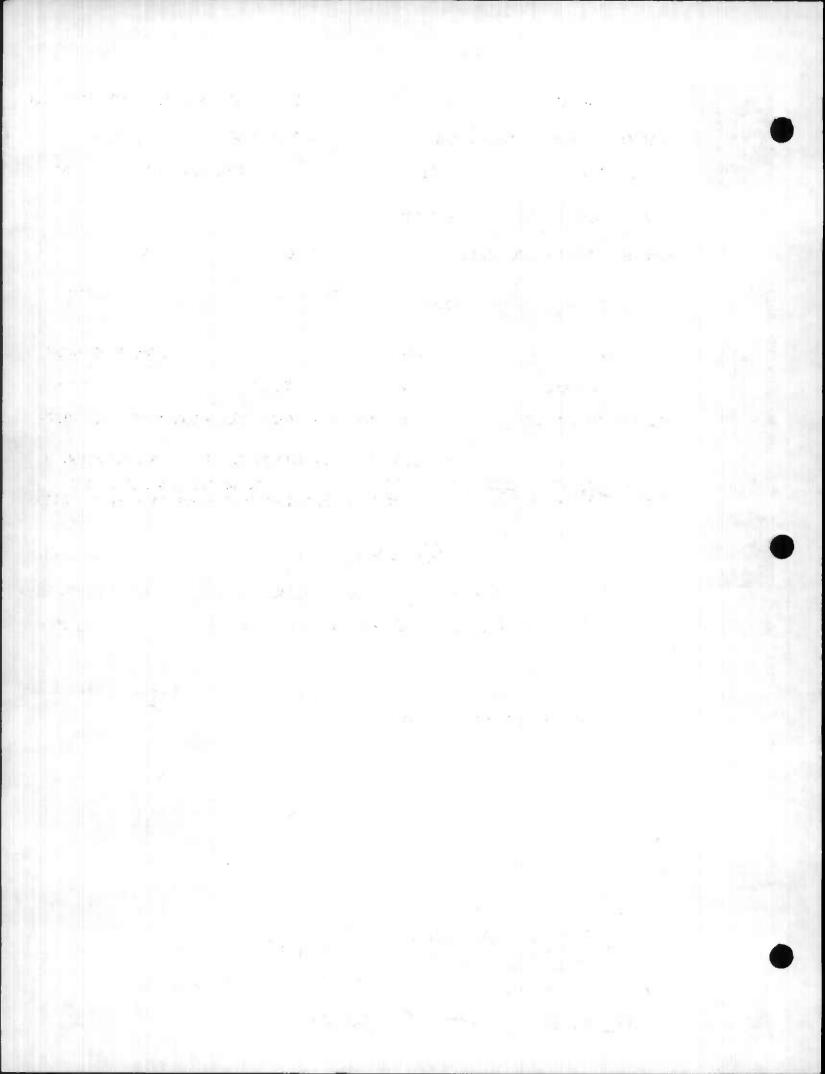
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

MID

Schwartz

32. Registrer's Signature

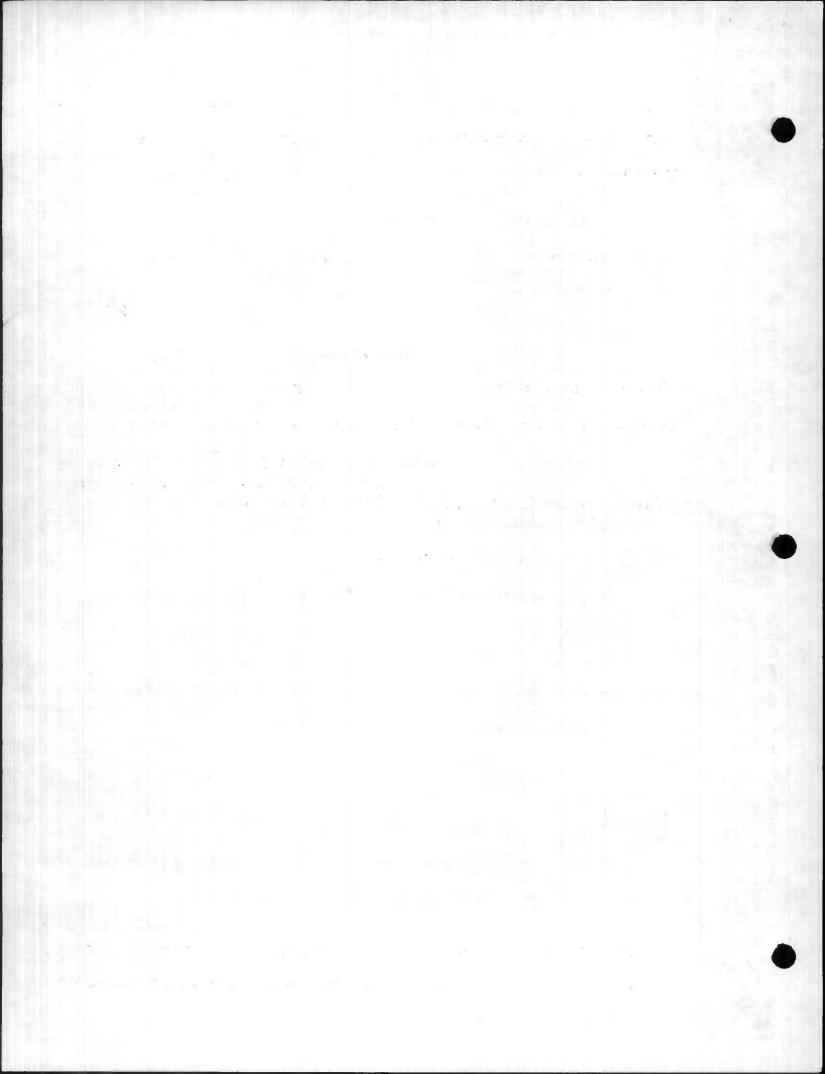
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THOMAS KASPER JR				State of M	laryland			f Health and of Death		gieneg 9	0 8	2864	
	_	edent's Name (First, Middle, Las	st)					2. Date of Dea	ath Dey	Year	3. Time of Death	
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	11. Ma	rital Status		12. Was Decedent Armed Forces	?	S. 13. W	as Decedent Yes, specify C	of Hispanic Origin? (S Cuben, Mexican, Puer	Specify Yes or No- no Rican, etc.)	- 14. Rec	e - Americ ck, White,		
20 s	_	Never Merried Widowed 4		1 ⊠ Yes 2 ☐ If Yes, Give Year or Dates:	No	1	□ Yes 2X	No Specify:		Specify	Whi	ite	
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and / man	Seque if any,	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury											
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of V physic this ce al dire	<u> </u>	XYes 2□ No)	Hospital: 1 ☐ Inpat		ER/Outpatient			Home 5 ☐ Resi			(y)	
Ing P	27. Mai	nner of Death	5 Pending	28a. Date of tnj (Month, D	ey Year)	28b. Time of Injury		Injury at Work?	28d. Describe	how injury occur	rred		
Division of Vital Records, or Attanding Physician: The law requires that data death. Director: After this certificata hes been signe in by the funeral director, page 2 should be can be a should be	2 3	Accident Suicide	investigation		tue. As to o	ma form stee		1 ☐ Yes 2 ☐ No	20f Location /	Street and Num	her or Run	al Route Number,	
Or All		Homicide	determined	Zoe. Flace of II	ic. (Specify	me, term, stre	et, factory, off	ice	City or To	wn, Stete)	Der Di Mari	arrione runiber,	
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6/1		me and address		completed cause of	death (Item	23a) (Type, I		enn Street	Raltim	ore Ma	ryl an	d 21201	
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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Dev THELMA IOLA KELLY February 2, 1999 Pation of Deeth 4c. County of Death 2:05AM 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Owings Mills ar If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Baptist Home of MD/DE Baltimore 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) 1 M 2 XF Months Days 91 Yrs. 220-14-9762 Usuel Residence of Decedent MD May 21, 1907 10a Stete 10h Counts 10c. City. Town or Location 10d. inside City Limits Baltimore 1 ☐ Yes 2 No Reisterstown 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 14. Race - American Indien, Bleck, White, etc. 117 Cherry VAlley Rd 21136 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) 12 Salesperson Sewing Machines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) John Momberger Elsie Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jerry Kelly Son 117 Cherry Valley Rd., Reisterstown, MD 21136 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1X Buriel 2 Cremation 3 Removal from Stete 4 □ Donetion 5 □ Other (Specify) 2/5/98 Cedar Hill Cemetery Baltimore. MD 21. Signature of Funeral Servica Lice 22 Name and Address of Facility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown. MD 21136 2.a. Part1. Priter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. Approximate Intervai Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequença of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably A Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy 2 8 No 200 No 1 Yes 1 Yes 26. Piece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 DiNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760. Physician/Medical thet the death certificate signed by the el Records, P.O. à should I Completed The law s certificate has b director, page 2 s Division of Vital or Attending Physician: director, Be 10 After this funeral Certification: To the Hospital or Attendir within 24 hours effer deeth. To the Funeral Director: A completely filled in by the fr deeth. edicai

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

Funeral

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7 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Metical Examiner must be not the data

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permit. Pages 1 and 2 should be file Department of Health and Mental Hyy Important: If item 27 is marked othe eny Injury or other treumatic event, page.

Physician /Medical

Examiner

25. Was case referred to medical 1 Yes 20 No 27. Menner of Death

281, Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) and manner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end manner steted.

29b. Signature and title of cartified

29c. License number

29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Dey, Year) 4 1999

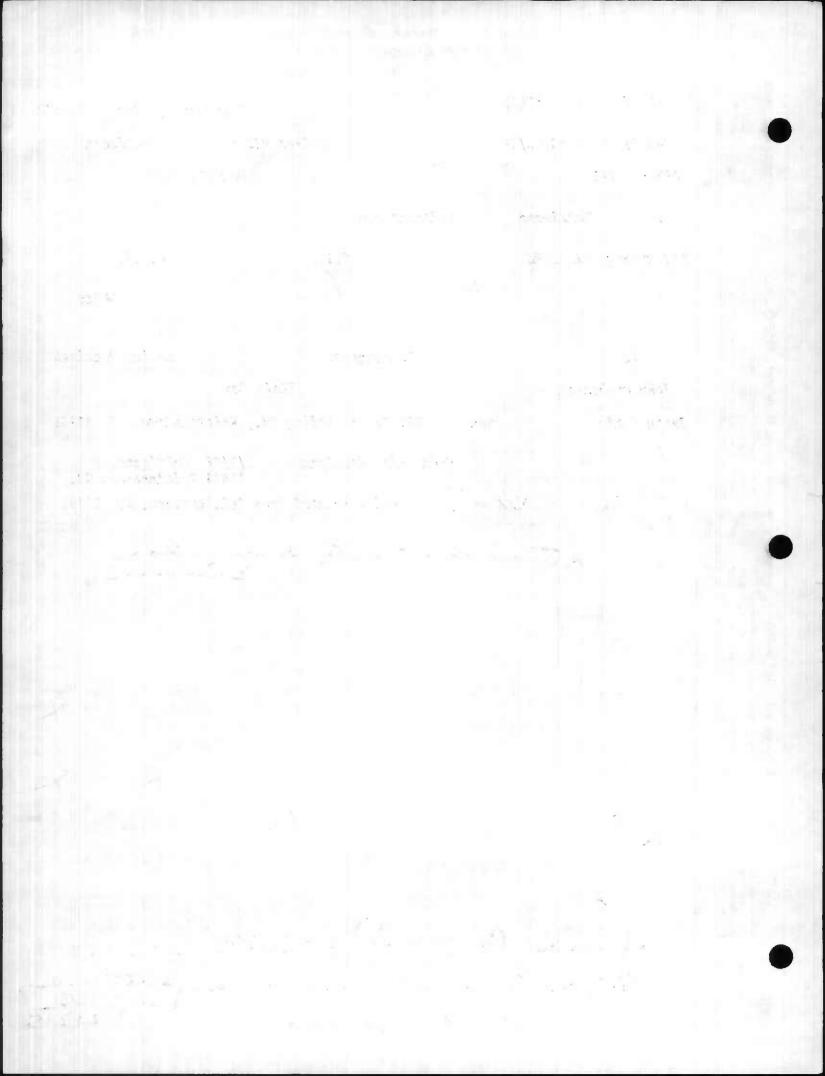
30. Name end eddress of person who completed cause of death (item 23e) (Type, Print)

32. Registrar's Signature

40.

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item#29d perPhy G768 2/4/98 EW Item#10d perFH G768 2/4/99 EW Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth Ivery ELwell KEKKY **Physician** Month 1028 (1) JANUAR 31 1999 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deel Examiner HARRISTOWN PALTIMORE CATON SVILLE 6030 o Ad If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1⊠M 2□ F Yrs. Director 246-42-5088 67 25 N.C. Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s4 show traumstic event, the Medical Examiner dwat be notified at Director Tes 20 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? U . S . A .

14. Race - Amarican Indien,
Black, White, etc. Funeral 6030 Harristown Road 21228 12. Wes Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examines page. 1 XYes 2 No If Yes, Give Yeer or Datas: Wever Married 2 Married by 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retirad) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) Coilage (1-4or 5+) 12th grade yrs Teacher Baltimore City 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Ernest Kelly Etta Singletary 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Edith Miller-Sister 6030 Harristown Road, Catonsville Md 20b. Place of Disposition (Nama of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Vet 2/5/99 Owings Mills Md 22. Name end Address of Fecility March F/H West Part Ephir the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, nock, or heart failure. List only one cause on each lina. 21215 Approximete Intarval Betw **Physician** /Medical Immediete Ceuse (Finel . AttoRoseleRogic CARDIOVASCULAR DISEASE diseese or condition resulting in death) Examiner Examiner tha bunal-transit Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): physician Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown by Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings eveilable prior to completion of ceuse of deeth? paga 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes cese raferred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4□ Nursing Home 54□ Residence 6 □ Other (Specify) 1 PYes 2 No Certification: To this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Aftar 1 Neturel 5 Pending eftar death. 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

Box 68760 P.0 Records, Division of Vital or Attending Physician:

with the Maryland

Baltimore, Maryland 21215-0020

within 24 hours eft To the Funeral Di completaly filled in

in by

4 Homicide

29a. Cartifian (Check on one) 29b. Signat

State Registrar

complated ceusa of daath (Itam 23a) (Type, Print) 31. Dete filed (Month, Day, Year) LIAMSOM # 32. Registrer's Signeture

4 1999

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1 Contifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Indedical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

28e. Plece of Injury - At home, ferm, streat, factory, office building, etc. (Spacify)

29d. Dete signed (Month, Day, Year)

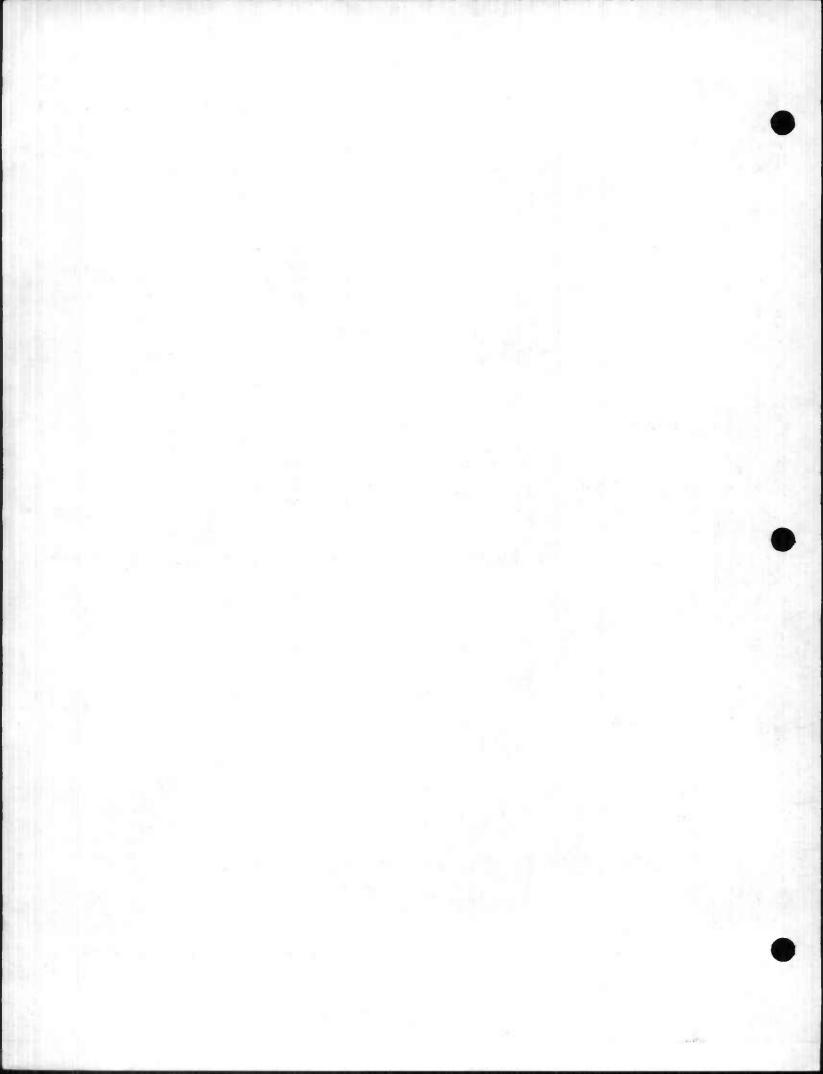
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State of Maryland / Department of Health and Mental Hygiene 99 02867

				(Certificate	e of	Death			Reg. No.	7 0	600) (
ysician	Decedent's Name (First, Char)		indsay					-4	2. Date of Do Month	eath Day	Year		a of Death	
edical	4a Facility Name (If not ins	titution, aiv	re street and number)				4b. City. To	own, or Lo	JANUAR ocation of Dear		1999 nty of Death		ות אח	
miner	Union Memo						Balti					more City		
	5. Social Security Number	6. S		e (In yrs. last birthe	Months	1 Year Days	If Under		8. Date of Bi (Month, D	rth sy, Year)	9. Birth Cou		te or Foreign	
r	Usual Residence of Decede		A 3		<u> </u>				May 2	4, 1961	unk	nown		
	10a. State 10b. C			10c. City, Town o	or Location							t0d. Inside	City Limits	
Director		timor	re City	Baltimo								1 G Yes 2 □ No		
al Dir	10e. Street and Number 1444 West 36	th St	treet		10f. Zip Code 21211					10g. Citizen of W U.S.A.				
runeral	11. Marital Status		12. Was Decedent	Decedent Ever in U,S. 13. Was Decedent of Hispar ed Forces? unknown If Yes, specify Cuban, M				igin? (Sp	ecify Yes or N		laca - Ameri),	
	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		1 Yes 2 I			ff Yes, specify Cuban, Mexican, Puèrto F 1 ☐ Yes 2 ☑ No Specify:				Spe		ck, White, etc. y: White		
	15. De (Specify only	cedent's Ed	ducation ade completed)	ation 16a. Decedent's Usual Occ. completed) (Give kind of work don life. DO NOT use retir				at of work	ing	16b. Kind of	Business/Ir	ndustry		
Contract of the second	Elementary/Secondary (0 unknown		College (1-4or 5)+)	iie. <i>DO NOT us</i> inknown	e retire	ed)			unkn	Otm			
	17. Father's Name (First, M	iddle, Last))		THE CHILD WILL		18. Moth	er's Name	First, Middle					
	unknown						unk	nown	ame (First, Middle, Meiden Sumame)					
	19a. Informant's Name/Rei	ationship (Type, Print)	19b. A	19b. Mailing Address (Street and Number or Ru					per, City or To	vn, Stete, Zi	p Code)		
	unknown			unknown			King I							
	20a. Method of Disposition			20b. Place of D		ne of ther pla	ice)		Date	20c. Location - City or Town, Stat				
	1 ☐ Burial 2 ☐ Crema 4 ☐ Donation5 ☐ Ott							1						
y injur	21. Signature of Funeral Se ROD	rviçe Licen			22. Name an	d Addre	ess of Facili	tx	ard, 655 W. Baltimore Street					
	MANCY	ald S	y wage,	rector					ard, 655 W. Baltimore Stree and 21201					
	23a. Part1. Enter the disea spock, or heart failure	se, or com	plications that caused	the death. Do no							1	Approxi	mate	
	spock, or heart failure	. List only	one cause on each li	ne.							1	Onset a	Between nd Death	
	Immediate Cause (Finat disease or condition		Mrm	CTATIO	F SORH	01	EAL	Co	NEER		1	2 vc	000	
	Immediate Cause (Finat disease or condition resulting in death) METASTATIC ESOPHAGEAL CANCER 2 YEARS Due to (or as a consequence of):											40>		
	ാര ര ശ്ര ഒ വേദ്യാത്യാത്രെ വു.										1			
	Sequentially list conditions,	nsequence of):						- i						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				,						1			
I	that initiated events resulting in death) Last	1	C	Due to (or as a consequence of):										
		· L	d											
l					Mark Table						1			
	Part II. Other significant co	nditions o	ontributing to death be	ut not resulting in th	he underlying ca	ause gi	iven in Part	l.	23b. Did	1obacco use	contribute	to the cau	sa of death?	
	HIV								1	Yes 2 N	o 3 Pro	obably 4	Unknown	
ĺ									24s Wes	an autopsy	24b. V	Vere auton	sy findings	
										ormed?	80	vailable prompletion	or to	
												f death?		
ŀ	OF Managements	adted 1								Yes 2 No	1	☐ Yes	2□ No	
	25. Was case referred to m examiner?	edical	Hospital:	· • • • • • • • • • • • • • • • • • • •		Ot	hor		h (Check only		20. (0.			
ŀ	1 ☐ Yes 2 ☑ No 27. Manner of Death		1 ps. Inpatie	nt 2 ER/Outp		8c. Inju	4 LI NI	7		how injury oc		ify)		
ı		ending vestigation	28a. Date of Inju (Month, Da)	y Year) Inju	Iry M		ork?]Yes 2∐							
ı	3 ☐ Suicide 6 ☐ G	ould not be	8 28e. Place of Inju	ury - At home, farm	n, street, factory	, office				(Street and Nu	mber or Rui	rel Route f	lumber,	
l	4 Homicide	otominoq	building, etc	c. (Specify)					City or To	wn, State)				
	(Check only 2 Me	rtifying Phy dical Exam	ysician: To the best of niner: On the basis of	examination and/o	leeth occurred a	at the ti	ime, date an opinion, dea	nd place, ath occurr	and due to the	cause(s) end date and place	manner as	stated. to the caus	se(s)	
	one) 29b. Signature-and title of c	ertifier	and manner ste	91 0 0.	200	Licen	se numbar			29d. Date sig	ned (Month	Day Ves	()	
	De la la la la la la la la la la la la la	4	3	4.0	100			0.1.						
1	Han	10.6	ellute, N			T	2438	446		JANUAR	Y 28	, 19	99	
	30. Name and address of po	rson who	completed cause of d	eath (Item 23a) (Ty	/pe, Print)	0		D		- M	21			
	RICHARD A. EL				RSITY	PAI	RKWAY	R	4LT IMO	RE MIA	KYLAN	0 21	218	
te ar	31. Date filed (Month, Day,			ar's Signature	9. Sp.	ock	1							



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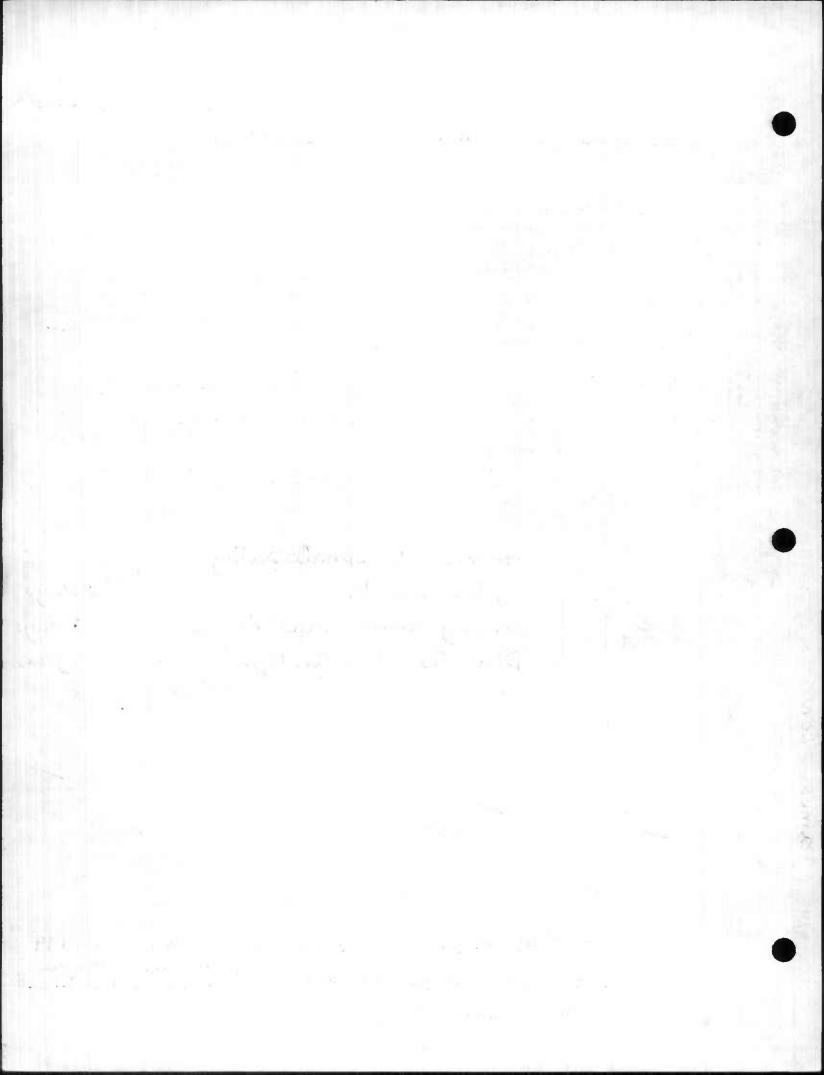
	State of Maryland / Department of Health an Certificate of Death	Reg. No.	9 02868			
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	Year 16.20 Pm			
/Medica	James Edward Long, 111	Jan 30 , or Location of Death 4c. Cou	1999 16.201 m			
Examine	0.1.	4-1	imore City			
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		9. Birthplace (Stete or Foreign Country) Maryland			
snyland show id.et	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore County Baltimore County	10d. Inside City Limits 1 ☐ Yes 2 ⊠ No				
with the Ma ta or 28e-f s	I IN HIISTING AVENUE	10g. Citizen	of What Country?			
020 urs after death at, or thems 28 Examiner must	11. Marital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, specify Cuban, Mexican, Fill Yes, specify Cuban, Mexican, Fill Yes, Give 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No		Race - American Indian, Black, White, etc. with: White			
Maryland 21215-0020 of 2 should be filed within 72 hours at the and Memal Pogiere. The marked other than "natural", or traumatic event, the Medical Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired) UNKNOWN	1 16b. Kind o UNKNO	1 Business/Industry			
D High	17. Father's Name (First, Middle, Last) 18. Mother's	Neme (First, Middle, Maiden Sun				
/lar Menta M	James Edward Long, Jr. Norma	a Elizabeth Schw	artz			
Mary and 2 sho alth and 27 is me or traume	19a. Informent's Neme/Relationship (Type, Print) Delores Vita/cousin 19b. Meiling Address (Street and Number of Parks) 999 Lanna Way, Annap					
altimore mit. Pages 1:s partment of He portent: If Hen y Injury or othe	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel Irom Stete 4 ☑ Donation—5 ☐ Other (Specify)	Dete 20c. Location	on - City or Town, Stete			
Balt pemit. Depart imports any ink any ink	21 Signature of Furtheral Service Licenses Ronald S. Jace Director 22. Neme end Address of Facility State Anatomy Bo Baltimore, Mary		timore Street			
Carbon and Carbon and	Cause (Disease or injury that initiated events resulting in death) Last Due to or es a consequence of):		2 days 5 days			
P.O. BOX 6 hat the death certifi d by the ettending leteched for use as	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	ape II	contribute to the cause of death?			
	The state of the s	1 Yes 2 N				
ew requ		24a. Was an autopsy performed?	24b. Were autopsy lindings available prior to completion of cause of death?			
- F # 6 0		1□ Yes 2☑N	0 1□Yes 2₽No			
Of Vital Physician The Physician This certificate rail director, page CO	Hospital:	Deeth (Check only one)				
0 5 5 5	1 Impatient 2 EH/Outpatient 3 DOA 4 Nursi	28d. Describe how injury oc				
Division O To the Hospital or Attending Ph within 24 hours effector: After th To the Funerel Director: After th completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)	28f. Location (Street and No City or Town, State)	umber or Rural Route Number,			
he Hospita in 24 hours he Funeral pletely fille		plece, end due to the cause(s) and occurred at the time, date and pla	menner as stated. ce, and due to the cause(s)			
to the state of th	29b. Signature and title of certifier 29c. License number P 1259	15 Jan	gned (Month, Day, Year) -30 - 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agnes Hosp Mustapha Mallah M.D. StAgnes Hosp	pital 900 Ca Baltinu	ton Avenue ou, MD 21228			
State Registrar	FEB 0 4 1999 31. Date filed (Month, Day, Year) FEB 0 4 1999 32. Registrer's Signeture 6. Apacks					

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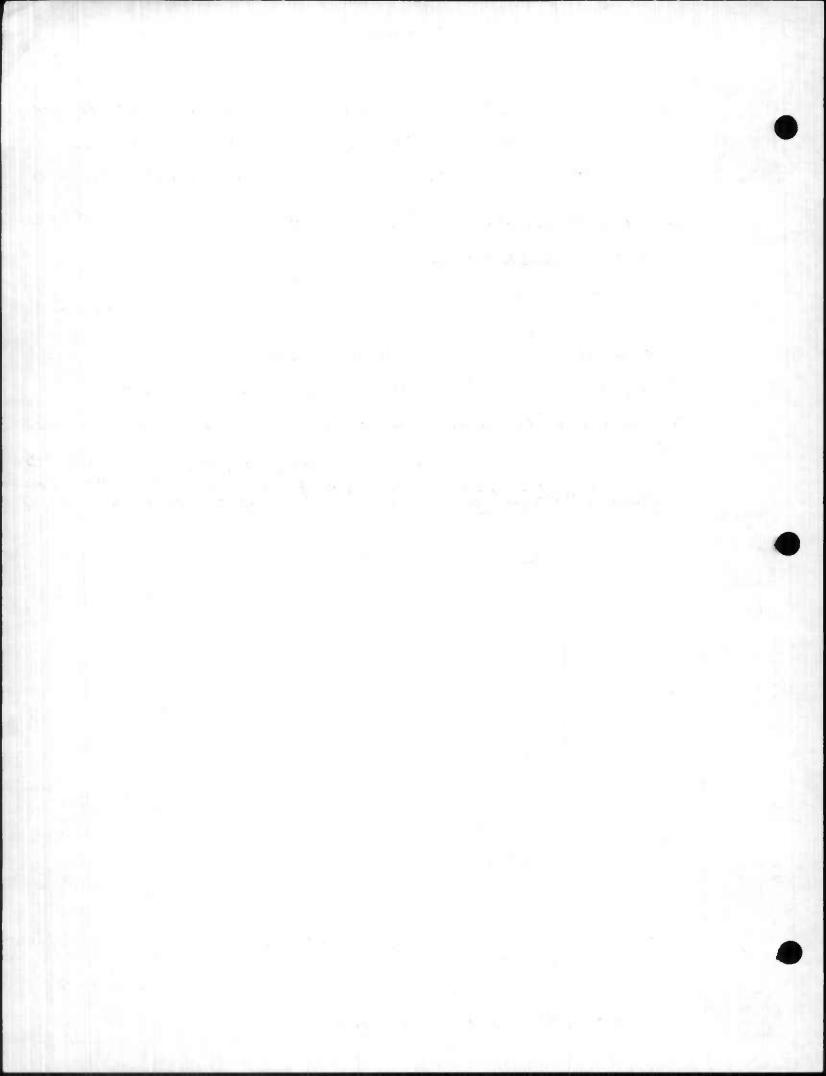
James

NAME



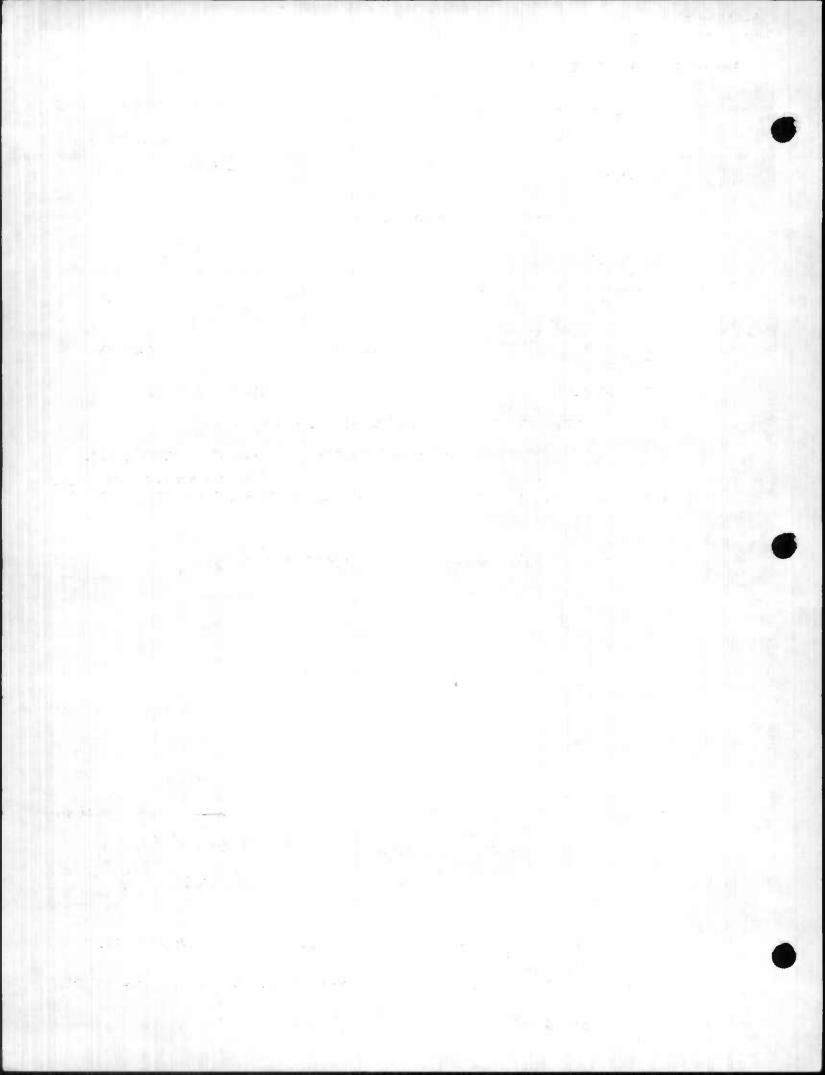
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneg

			, , , , , , , , , , , , , , , , , , , ,	Certifica	te of Death	Reg.	23	2869
Physi /Med	clan dical	1. Decedent's Neme (First, Middle, La	PEAR	L LA	WSON	2. Dete of Death	Day 1999	3. Time of Death 12:05AM
Exam Funera Directo	iner al	4a. Facility Name (If not institution, giv CHESAPEAK 5. Social Security Number 6. S 220 - 22 - 9641 Usual Residence of Decedent	= HOSPIC		E LINTH- er 1 Year If Under 24 Hrs	8. Date of Birth (Month, Day, Ye		COUNTY pplace (State or Floreign unity) RGINIA
anylend show	_	10a. State 10b. County		y, Town or Location				10d. Inside City Limits 1X Yes 2 □ No
020 urs efter death with the Marylen sl., or items 23e or 28e-f show Examiner must be notified at	by Funeral Director	10e. Street end Number	ICER ROAD 12. Wes Decedent Ever in U Armed Forces? 1 □ Yes 2 □ No	101. 2	ip Code 2 / 0 6 edent of Hispanic Origin? (secify Cuban, Mexican, Puer	0	Citizen of What Cou	untry?
hours wrat.		3 □ Widowed 4 □ Divorced 15. Decedent's Ec	If Yes, Give Year or Dates:	1 ☐ Yes	2A No Specify:	10	_	LACK
2121 d within jiene.	Completed	(Specify only highest green Elementery/Secondary (0-12)	de completed) Coilege (1-4or 5+)	(Give kind of v	rork done during most of wo	orking	5 WN F	HOME
Maryland 2 d 2 should be filed th end Mental Hygi 7 Is merked other traumatic event, I	To Be	17. Father's Name (First, Middle, Last) ROBERT	DRI	1 MMO NE		me (First, Middle, Mele	den Sumeme) TO NE	S
Pages 1 en ent of Heal		19a. Informant's Name/Relationship (1) JoSEPH LAWSO 20a. Method of Disposition 1 Burial 2 Cremation 3 Company 4 Donetion 5 Other (Specify	(ype, Print) (HUSBAND) 200. F Removal from State	19b. Mailing Address 7849 S Place of Disposition (Nemetery, cremetory or	ss (Street end Number or F PENCER R eme of	Date 200	BURNIE Location - City or T	MD. 21060 Town, State
	TO THE PARTY OF TH	23a. Plant: Enter the disease, or companies only on the control of	olications that caused the deat	22. Name JOSU 214	and Address of Fecility BA SPH H. BA ON FULTO	NAVE, BI	ALTIHORE	RAL HOME Approximate Interval Between Onset and Death
Physician /Medica Examine	r r	Immediate Cause (Final disease or condition resulting in death)		Vasaula or as a consequence o	c Accid	ent (Steo	he)	32 nos.
I Records, P.O. Box 68760, The law requires that the death certificate be executed to the been signed by the ettending physician and page 2 should be detected for use as the buriel-trans-	n/Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	C	r as a consequence of				
P.O. By that the death ed by the ette deteched for	Physician/M	Pert II. Other significant conditions of	entributing to death but not res	ulting in the underlying	cause given in Part I.	23b. Did tobac	7	to the cause of death?
Records, F ne law requires that shes been signed l ge 2 should be det	Completed by					24e. Was an a	17 a	Vere eutopsy findings iveileble prior to completion of cause of death?
		25. Was case referred to medical				1 ☐ Yes	20 No 1	□Yes 25/No
0 = = 5	ation: To Be	examiner?	Hospital: 1 Inpatient 2 Inpatient 2 Month, Dey Year)	ER/Outpatient 3 I	Other:	Home 5 Residence 28d. Describe how i		in Hogoid Hour
Division al or Attending s efter death. Il Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, facto	ry, office	281. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
Dithe Hospital or within 24 hours efter To the Funeral Director Completely filled in	edical	29a. Certifier (Check only one) Certifying Phy 2 Medicat Exam	raician: To the best of my kno iner: On the basis of examinal and manner stated.	wledge, death occurre tion and/or investigetion	d et the time, date and plac n, In my opinion, deeth occ	e, and due to the cause urred et the time, dete	e(s) end menner es end place, and due	stated. to the ceuse(s)
To th To th comp	Me	29b. Signature and little of certifier	Mach	was 2	9c. License number	7 290.	bsugned (Month)	3 1999
		30. Name and address of person who	ompleted gause of deeth (Item	23e) (Pype, Print)	Cigin Hiel.	n Glent	Swaie, M.	2/06/
S Regis	tate trar	31. Date filed (Month, Day, Yeer)	32. Registrar's Signa		7.	D	a verification	1



32. Registrar's Signature

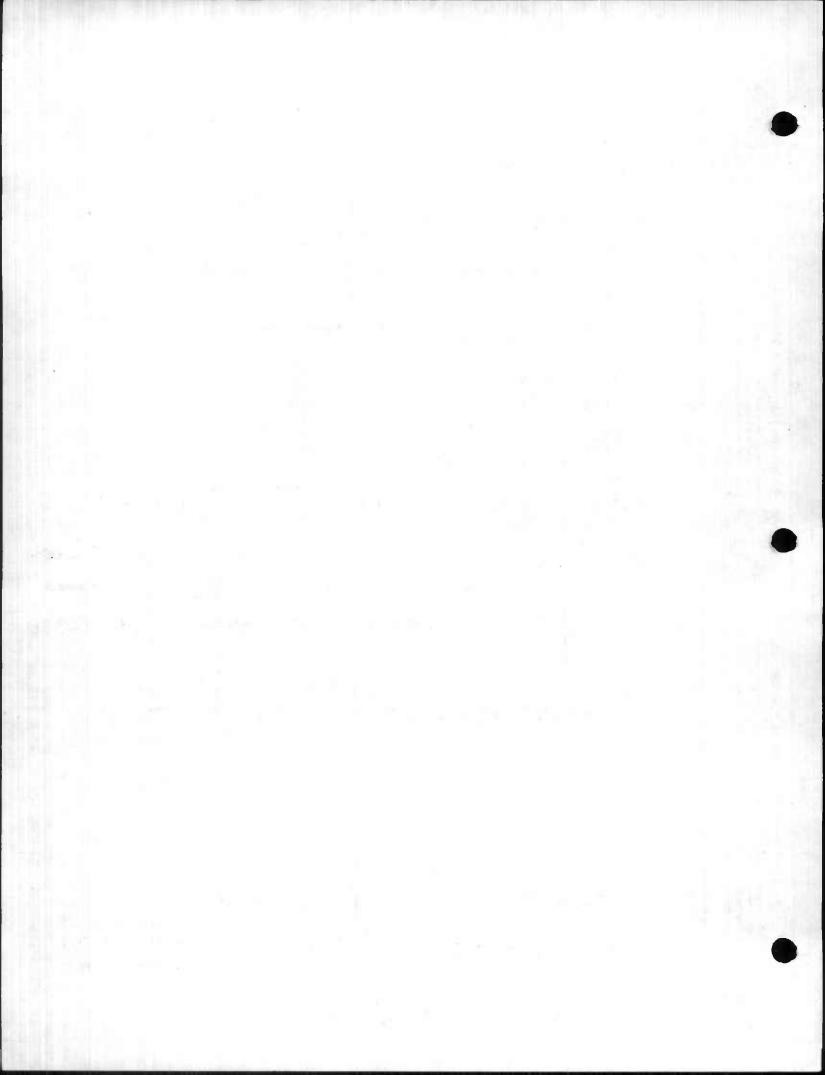
State Registrar



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middla, Last) 3. Time of Death 2. Date of Death Month **Physician** 945 DONGTHY m. LONABERGER Lucional 1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Greater Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 21 F 213 42 9295 Yrs. 55 Director 30, 1943 Washington D.C Usual Residence of Decedant r 25a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yas 2 No Maryland Prince George's Laurel Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 r than "natural", or hams 23s or the Medical Examiner must be 20708 9001 Cherry Lane United States 14. Rece - Amarican Indian, Black, Whita, atc. 11, Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 1 □ Never Married 2 □ Merried Maryland 21215-0020 1 Yas 2 No Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) System's Analyst 0.P.M. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Frank Edward Aldridge, Sr. Dorothy M. DeGraffreid 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edron R. Lonaberger son 12636 Gray Eagle Ct. Germantown Maryland 20874 Baitimore, 20b. Place of Disposition (Name of cematary, crematory or other place) Feb. 3, 20a. Mathod of Disposition 20c. Location - City or Town, Stete Date 1999 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood Maryland 22. Nema and Addrass of Facility
Robert E. Evans Funeral Home, Inc. 21. Signature of Funeral Service License 16000 Annapolis Rd. Bowie Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onset end Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical 15P515 SER Examiner Dua to (or as a consequence of): Examiner LOGE (SUMMUS) attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of). FOIED REICHS Box 68760 the death certificate be Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yas 2 20 3 Probably 4 Unknown may 1715 b 24b. Wara autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 Yas & No 1 ☐ Yas >BNo certificata of Vital 25. Was casa referred to medical axaminer? 8 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yas 250No P 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Division or Attending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun - Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) end mannar as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to tha cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier Joseph 71, 1999 1725422 BACTIMONE ANS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13952 Rosenv W197814 MO 20707 (1000×400×10) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month, 1999 0 reb 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Catousville Macintosh Baltimore 5. Social Security Number 212–48–3788 7. Aga (In yrs. last birthday) 91 Yrs. If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth Nov. 0, 1907 9. Birthplaca (Stata or Foraign Country) Mary Land Days 1□ M 2□ F Usual Rasidance of Decedent 10h County 10c. City, Town or Location 10d. Insida City Limits Baltimore 1 Tyas 2 No Catonsville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3 McIntosh Court, Apt J. 21228 U.S.A. 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 □ Nevar Married 2 □ Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuai Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT use ratired) Elamantary/Secondary (0-12) Coliaga (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Elmer Kernev Matilda Poole 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary H. Hunt (granddaughter) 3 McIntosh Court Apt J Catonsville, MD 21228

a. Mathod of Disposition

1 Burial 2 Cremation 3 Removal from State

1 Burial 2 Cremation 3 Removal from State 1 Burial 2 Cramation 3 Removal from Stata
4 Donation 5 Mother (Specify) Entombment Loudon Park Mausoleum 2/5/99 Baltimore, Maryland 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc.

Physician /Medical

Department of Health are Important: If Item 27 is any injury or other trau

Physician

/Medical

Examiner

10a Stata

Funeral

Director

28a-f show

6 must be

'natural', or Items 23a

72 hours after

Pages 1 and 2 should be filed within sent of Health and Mental Hygiene. nt: If them 27 is marked other than "

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

the Medical Examiner

Director

Funeral

þ

Completed

Examiner physician and s the burial-transit The law requires that the death certificate be executed

been signed by should be detac

page 2

this certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Examiner Physician/Medical à Be Completed

25. Was casa rafarred to medical Certification: To 27. Mannar of Death

disaasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated events rasulting in death) Last

1 Yas

+ Natural

2 Accidant

3 ☐ Suicida

29a. Cartifian

4 - Homicida

Rhot

immediata Causa (Finai

Dua to (or as a consequence of):

Parl II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Tima of

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28a. Data of Injury (Month, Day Year)

23a. Parl 1. Entar tha disaasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Dua to (or as a consequence of):

23b. Did tobacco uss contribute to the cause of death? 1 - Yes 24a. Was an autopsy performed? 1 Yas No

1630 Edmondson Avenue, Catonsville, MD 21228

Embolic Disease

3 Probably 4 Unknown 24b. Wara autopsy findings available prior to

Intarvai Batween Onsat and Death

completion of causa of death? 1 ☐ Yas 2 ☐ No

28. Placa of Death (Check only ona) Othar: 4 Nursing Homa Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Estifying Physician: To the bast of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifler

5 Panding

Invastigation

6 Could not be datarmined

29c. Licansa number

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

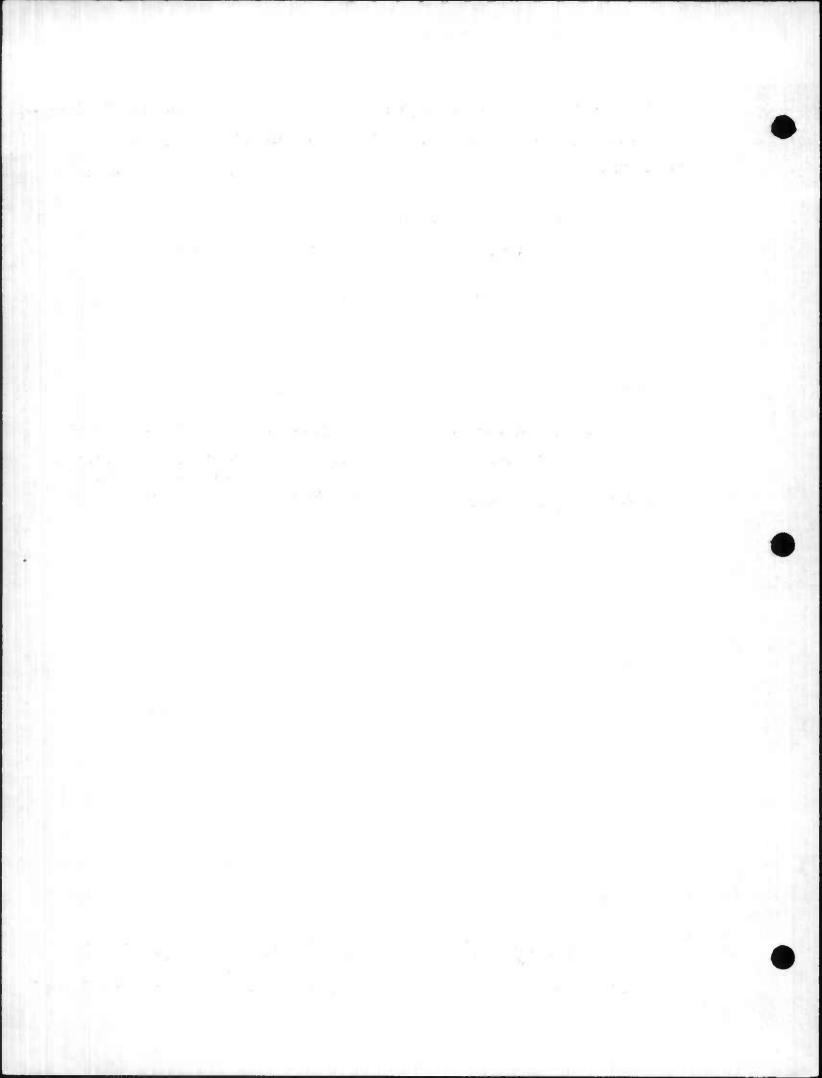
1518 Sulphur Spring Road Arbutis MD 2 1227 uliquire 31. Data filed (Month, Day, Year) > .

State Registrar

Medical

32. Registra Signatura 1999 FEB

28c. Injury at Work?



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Data of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 415pm Month **Physician** JANIVALY 3 | 1999 cation of Death | 4c. County of Death NORMAN LABOVITZ /Medical 48 Fecility Neme (II not institution, give street and number) Sinai Hospital of Battimane 4b. City, Town, or Location of Death Examiner Baltimore If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10XM 2□ F Months Days 215-07-0617 Yes 88 **Director** Usual Residence of Decedent with the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at BALTIMORE BALTIMORE 1 ☐ Yes 2 X No MD Director 10g, Citizen of What Country? 10e. Street end Number 10f. Zip Code 725 MT. WILSON LANE 21208 U.S.A. Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status after 1 ☐ Yas 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Aq WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) OWNER JEWELRY STORE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mentel 1 end 2 should be is marked LABOVITZ ZIFF REBECCA **JACOB** 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) JEAN LABOVITZ / WIFE 725 MT. WILSON LANE - BALTIMORE, MD Department of Heelth important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State BETH EL MEMORIAL PARK 2/2/99 RANDALLSTOWN, MD any injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** to (or as a consequence of): Examiner or Pation phenmonia certificete be executed ician and burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last Dementia Box 68760 physician Physician/Medical Due to (or es e consequence of): the 88 080 P.0. Part II. Other eignificent conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of deeth? detached the Parkinson's disease 1 ☐ Yee 2 ☐ No 3 ☐ Probably (Unknown signed by Division of Vital Records. by 8 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28 No 10 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? After t of or Attending P. after deeth. 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Roula Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funersi Di Certifying Phyeicien: To the best of my knowledge, death occurred et tha tima, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical (Check only one)

State Registrar

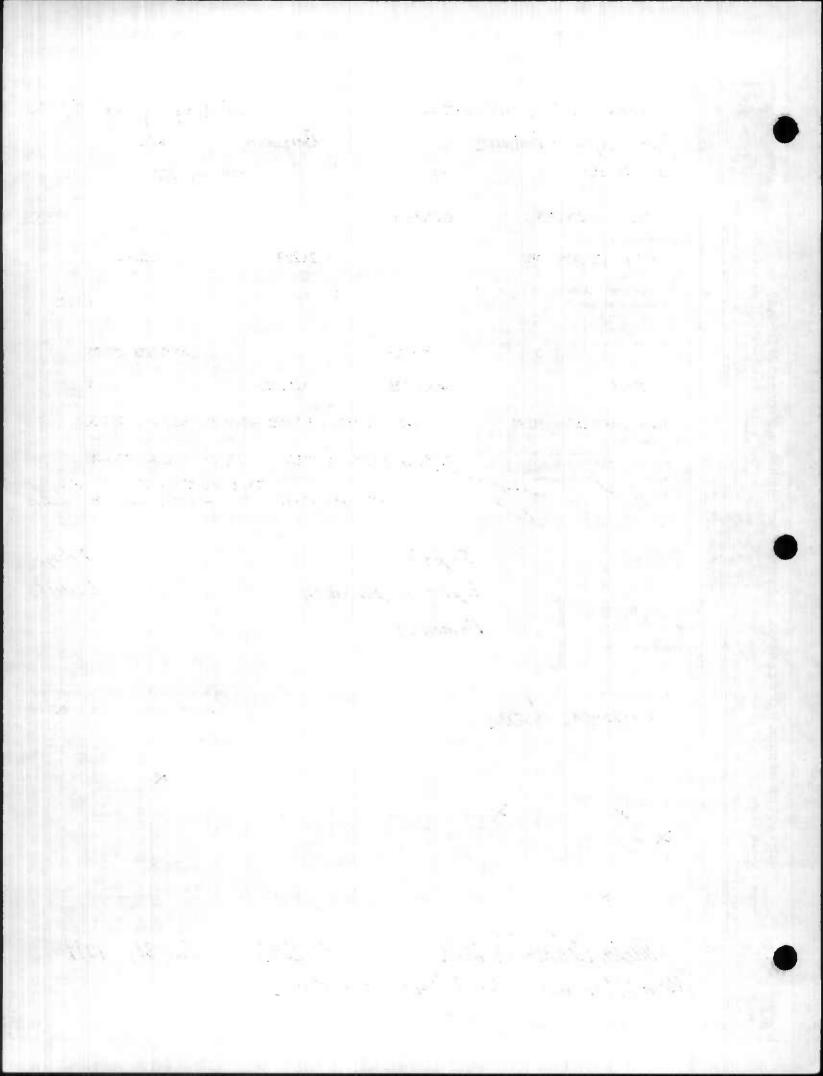
31. Date tiled (Month, Day, Year)

29b. Signature and title of certifies

Hospital 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and	Mental Hygiene		
Certificate of Death	Reg. No.	9 0	2874
	2. Date of Death	Veer	3. Tima of De

Physic /Med Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important if Nem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified as obdes. Baltimore, Maryland 21215-0020

Physician /Medical Examine

To the Hospital or Attending Physicien: The law requires that the death certificate be set within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 2 should be detached for use as the burns.

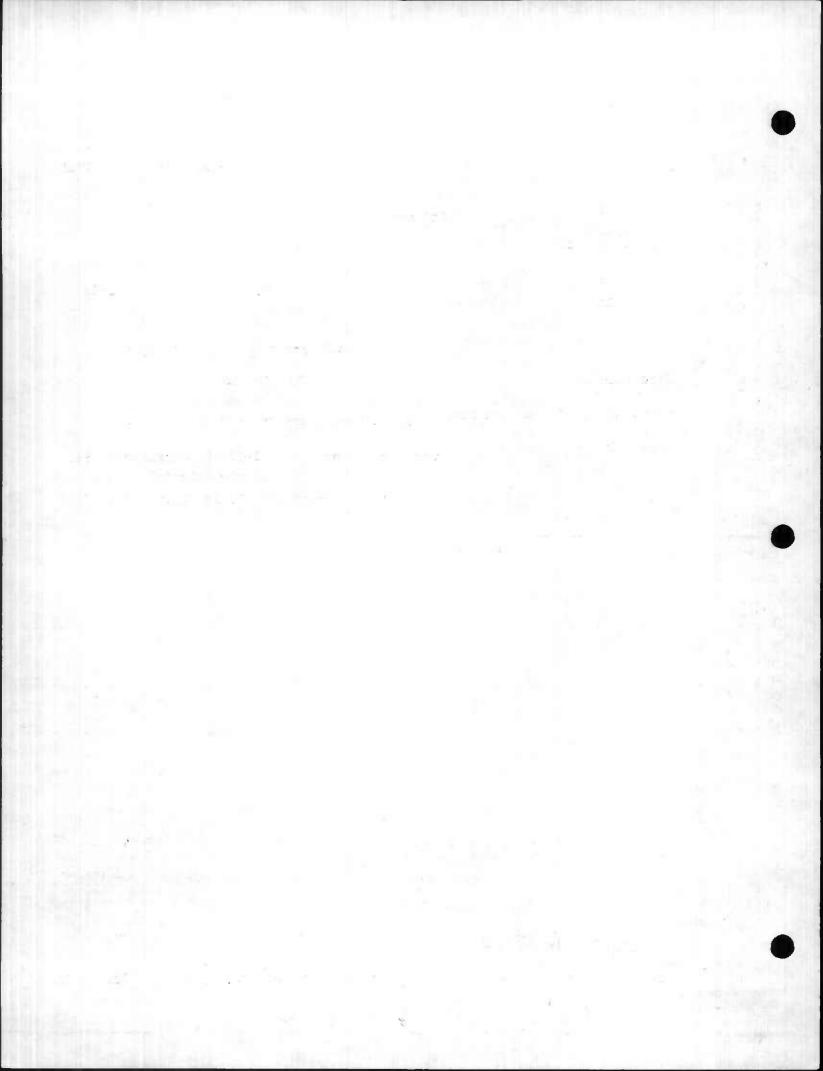
Division of Vital Records, P.O. Box 68760,

			Certifica	te of	Death			Reg. No.	9 0	287	1 Ls	
1. Decedent's Name (First, Middl	le, Last)						2. Date of De	ath	Veer	3. Tima	of Deeth	
Hoa H. Ly							JANUAF	RY 19	1999	223	5 P	
4a Facility Name (If not institution 1633 SEXTON	n, give street and number ST .	ber)			4b. City, To BALTI		ocation of Death		ty of Death			
5. Social Security Number 586-32-2897	6. Sex 7.	. Age (In yrs. last t	Yrs. If Under Months	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da May 4,	y. 1934	9. Birthplece (State or Fo				
Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location						10d. Inside City Lim			
Maryland		Balti	more							1XX Ye	s 2 N	
10e. Street and Number 1633 Sexton St	reet		10f. Z	ip Code	2123	30		10g. Citizen of USA	What Cou	ntry?		
11. Marital Status	12. Wes Deced	ent Ever in U,S.	13. Was Deco	edent of I	Hispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	- 14. Re		ican Indian,		
1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes				rican, etc.)	Spec	eck, White, ity: As	sian				
	t's Education st grade completed)		ia. Decedent's Usi (Give kind of w life. DO NOT	ork done	during mos	t of work	ting	16b. Kind of	Business/In	idustry		
Elementary/Secondary (0-12)	8 College (1-4	ior 5+)	Med	ical	Doct	or		Medici	ne:			
17. Father's Name (First, Middle, Ngoc Toan Ly	Last)					Die	e (First, Middle, p Le	Meiden Suma	ıme)			
19a. Informant's Name/Relations	thip (Type, Print)	19	9b. Mailing Addres	s (Street	and Number	er or Run	ral Route Numbe	er, City or Tow	n, State, Zij	p Code)		
Genevieve H. R	dumian/ Dau	0	723 Whit		Court	Spr	ingfiel	d, Va.	22153	3		
20a. Method of Disposition Disposition Disposition Disposition Disposition Disposition Disposition		ate cemei	of Disposition (Nation), cremetory or ly Crema	other pla		1	Date -23-99	20c. Location	- 7			
21. Signature of Funeral Service	//		22. Name e				erly-Co					
1/4	Tro	VIY CEN	(1)(1)								me	
23a. Part1. Enter/the disease, or shock, or heart feiture.	11		n not enter the mo	Lees	burg .	Pike	Falls	Church	Va.	Approxim		
shock, or/heart feiture. Light	fonly one cause on eac	ch line.							1	Intervet B Onset and		
Immediate Cause (Finat	11								1			
disease or condition resulting in death)	a	DNGINC	1									
		Due to (or as	a consequence of):								
	b								<u> </u>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as	e consequence of):					i			
Cause (Disease or injury	с								1			
resulting in death) Last	d	Due to (or as a consequence of):										
							1 4-1		t			
Part II. Other significant condition	ons contributing to deal	th but not resulting	in the underlying	cause gr	ven in Pert I	l.		Yea 2 No	,	obably 4		
							24a. Wes	en eutopsy	24b. W	Vere autops	y findings	
							pend	ormed?	C	ompletion of death?		
							10	Yes 25 No			₽ No	
25. Was case referred to medical					00 DI	-(Da				165 2	73 MO	
examiner?	Hospital:			Ot Ot	hor		th (Check only o		wh 40°	** 1		
1 ☑ Yes 2 ☐ No 27. Manner of Death	1 ☐ Ing		Outpatient 3 0	OA	4 LI N	ursing Ho	28d. Describe			ily)		
1 □ Naturat 5 □ Pendin	(Monin,	Day Year)		28c. Inju Wo	rk? Yes 200	Ko	Suns si			5.01	=	
2 Accident investig	not be	f Injury - At home,	4701			175	28f. Location (
4 ☐ Homicide determ	building	, etc. (Specify)		· y , On 108			City or Toy	wn, State)				
(Check only 2 Medical	g Physician: To the be Examiner: On the bas	is of examination a	ge, death occurred				and due to the	cause(s) and i	manner as :	stated.		
ane) 29b. Signature and title of certifie	and manne	r stated.	20	an Linan	se number			29d. Date sign	ned (Manth	Day Vos)	
Dayre (Merchel	e wy		O.C.				JANUAR				
30. Name and address of person MAYYANAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	who completed cause	of death (Item 23a		Penr	Stre	et,	Baltimo	ore, Ma	rylan	d 212	01	
31. Date filed (Month, Day, Year)		pistrer's algnature	1.	4	9 .							
EF	B 4 1999	Dener	w B.	1	oaks	1						
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DHMH 16 Rev 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Day 2, 1999 **Physician** 6:30 A.N Albert D. Bates, Jr. 4b. City, Town, or Location of Death 4c. County of Death /Medical 4e Facility Name (If not institution, give street and number) Examiner Roseclale
If Under 24 Hrs. 8. Date of Baltimore Square Hospital Klina Center If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours XXM 20 F 73 Yrs. 219-18-0363 **Director** May 31, 1925 Baltimore, Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits flams 23a or 28a-f show YOYes 2 No must be notified Director MD Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 8040 Philadelphia 21237 United States Funeral 12. Wes Decedent Ever in U.S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Rieck. White, etc. 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Year or Detes: 1941–45 'natural', or 1 ☐ Yes 2 ☐ No Specify: Specify: by 3 NWidowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) A & P Warehouse Order Picker 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Albert D. Bates, Sr. Eva Hendrex 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) important if then 27 is a any injury or other trees. 1515 Rosewick Avenue, Rosedale, MD 21237 Pauline Agnes/Niece 20b. Piece of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 2/6/99 Baltimore, MD 21. Signa ral Service Lices 22. Nama and Address of Facility Loudon Park Funeral Home, 3620 Wilkens Avenue Baltimore, Maryland 21229 Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feilure. List only one ceuse on each line. Physician Pneumonia Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or as a consequenca of): Physician/Medical Examiner 2 Weeks rosepsis Sequentially list conditions, it any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Doe to (or es a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown signed b by 24b. Were autopsy findings aveileble prior to complation of causa of deeth? Completed 24a. Wes an eutopsy performed? 2 No 1 ☐ Yes certificate or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitei: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No P this 27. Menner of Death 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred Certification: After 1 Netural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: / d in by the 6 Could not be determined 3 Suicida 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours aft the Funeral DI npletely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and megner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signeture and file of certific Stule no. 29d. Date stoned (Month, Day, Year) 29c. Licansa number

DHMH 16 Rav 6/95

State Registrar

Records, P.O. Box 68760

Division of Vital

9000 Franklin Square

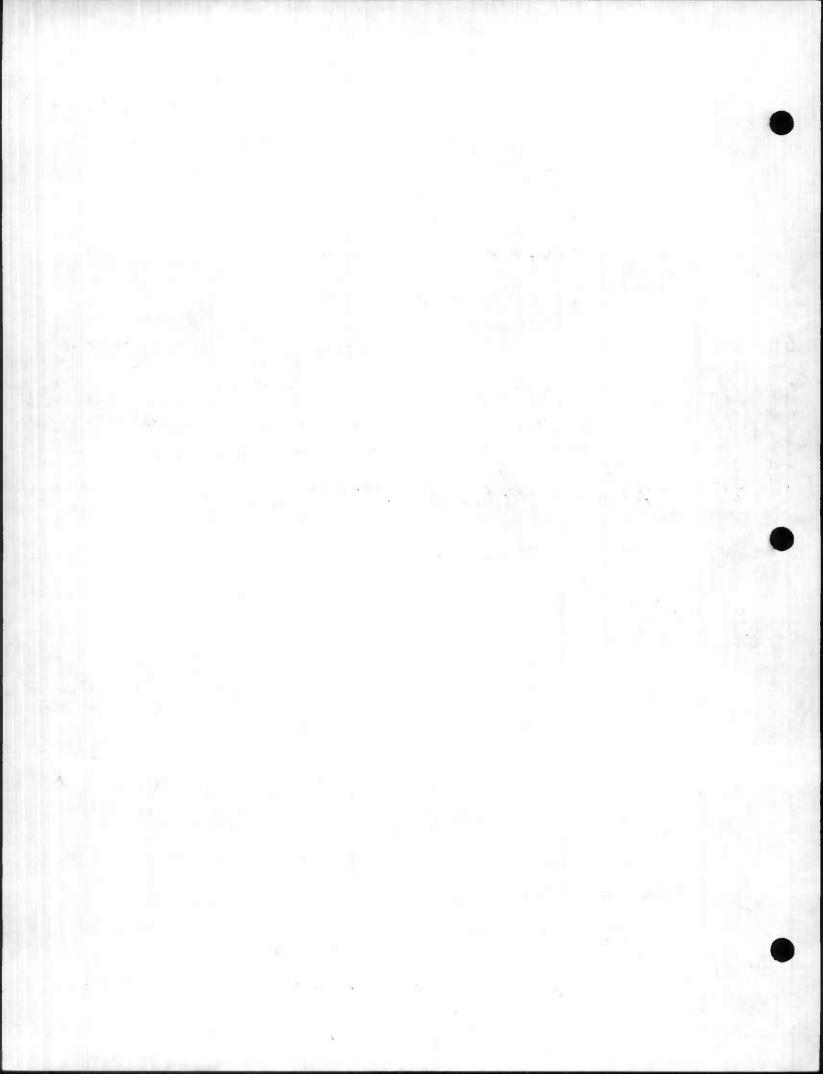
32. Registrer's Signeture

30. Name end address of person who completed cause of death (item 23a) (Type, Print)

FEB 4 1999

Dr Laura Dte 31. Dete flied (Month, Day, Year) 191874

Drive Baltimore, MD 21237



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	It	em#	7 perFH G768 2/4/99 EV			ertificate of			leg. No.	UZ	8/6	
	Physic /Medi			- PANKU				2. Date of Dea	31	Year 99	3. Time of Death	
	Examii	ner	4e. Facility Name (If not institution, gi MAHNER HEK		ocation of Death	_	BAUTIMORE					
	Funeral Director		5. Social Security Number 6. 219 - 01 - 4116		e (In yrs. last birthd	Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Dey			ice (Stete or Foreign y)	
	show solat	2	Usual Rasidanca of Dacedent 10e. Stete 10b. County MD Baltimo		10c. City, Town or			10d. Inside City Lim 1 ☐ Yes 2 ☑				
	the M	ecto	10e. Street end Number)I e	Catonsv	10f. Zip Code		1 ☐ Yes				
	3a or	io is	1910 Clifden Rd.			2122	28	USA	Wilat Court	y:		
020	2 should be file end Mental Hy is marked other eumstic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent Armed Forcas? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates;	- Silbilli	3. Was Decedent of if Yes, specify Cul	0	pecify Yes or No- Prican, etc.)	14. Rad Bla Specif	ce - America ck, White, e		
		Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	(G	cedant's Usual Occu ive kind of work done a. DO NOT use retin	during most of work	king	16b. Kind of B			
		Be	17. Fathar's Name (First, Middle, Las George Unger	")		770.	18. Mother's Nam	Name (First, Middle, Maiden Surneme)				
		To	19a. Informant's Name/Ralationship James Franklin/S		t end Number or Ru	ncis Shepke or Rural Route Number, City or Town, Steta, Zip Coda) Ellicott City, MD 21042						
nore,	00-		20a. Method of Disposition 1 X Burlai 2 Cramation 3		20b. Place of Di cemetery, o	sposition (Name of trematory or other place Park Ceme	ace)	Date	20c. Location	- City or Tow	n, State	
Baltimore,	permit. Pege Depertment of Important: If any Injury or once.		4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice	**	02/03/99 Baltimore, MD ral Home							
	_		23a. Part1. Enter the disease, or con shock, or heart failure. List on	plications that caused	the death. Do not		, MD 2122 ing, such as cardiac		rest,		Approximete	
	Physician /Medical Examiner		shock, or heart failure. List only Immediata Causa (Final disease or condition resulting in death)	a.	Delye Due to for all a con	tralio	n				nterval Between Onset and Death	
_	B %/	niner		b	}	month						
ó,	The state of the s	Examiner	Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury		Due to (or as a con	sequence of:						
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. Box	the death certify the ettending sched for use e	Physician/M	Part II. Other algnificant conditions	contributing to death b	iven in Part I	23h Did to	nhacco usa co	ntribute to 1	the cause of death?			
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9	ew requisite to the second sec	Completed b	Cereben	ascul	lar A	Cad	ent	24a. Was a perfor	an autopsy med?	avai	e eutopsy findings lable prior to pletion of cause eath?	
e H	Da de							1□ Y	es 2 No	10	Yes 21 No	
<u> </u>	Physician: The this certificate ral director, pag	o Be	25. Was case referred, o medical axaminar? 1 ☐ Yes 2 ☐ No.	Hospital:		OI 204 OI	26. Place of Daa					
	er this	n: To	27. Manper of Death	1 ☐ Inpatie	ry 28b. Time	a of 28c. Inju	4 Nursing H	ome 5 Residence 128d. Describe h				
Division	To the Hospital or Attending Is within 24 hours effect death. To the Funeral Director: Affer completely filled in by the funer	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be datarmined	n De One Blace et la l	ury - At home, farm,]Yas 2□No	28f. Location (S City or Tow	treet end Numi n, State)	ber or Rural	Route Number,	
	To the Hospital within 24 hours e To the Funeral C	Medical Ce	29a. Cartifiar (Check only one) 12 Certifying Pt	nyalclan: To the best of miner: On the basis of end menner sta	axamination and/or	eath occurred at the tinvestigation, in my	ime, data and placa, opinion, daath occur	and due to the c red at tha tima, d	ause(s) and malata and place,	anner as sta and due to t	tad. he cause(s)	
	within To th	Me	29b. Signature and title of certifier			29c. Licen	se number	2	29d. Date signe	d (Month, D	ey, Year)	
	1()		30. Name and address of person who	Kaus completed cause of d	Wew aath (Item 23a) (To	D Print	2630	7	2/1/	99		
_	10		RANIS. KARIE	INENI	H-000	ANNAPOL	ISRD.	BALT	IMOKO	5 MI	2/227	
	Sta	200	31. Date filed (Month, Day, Yaar)	32. Registr	Signature	B. 10	andel					

Manager No. of Mills of State of Mills of State of the St T. J. J. 115-16-18 80 Juja rango Yang N N. Agains

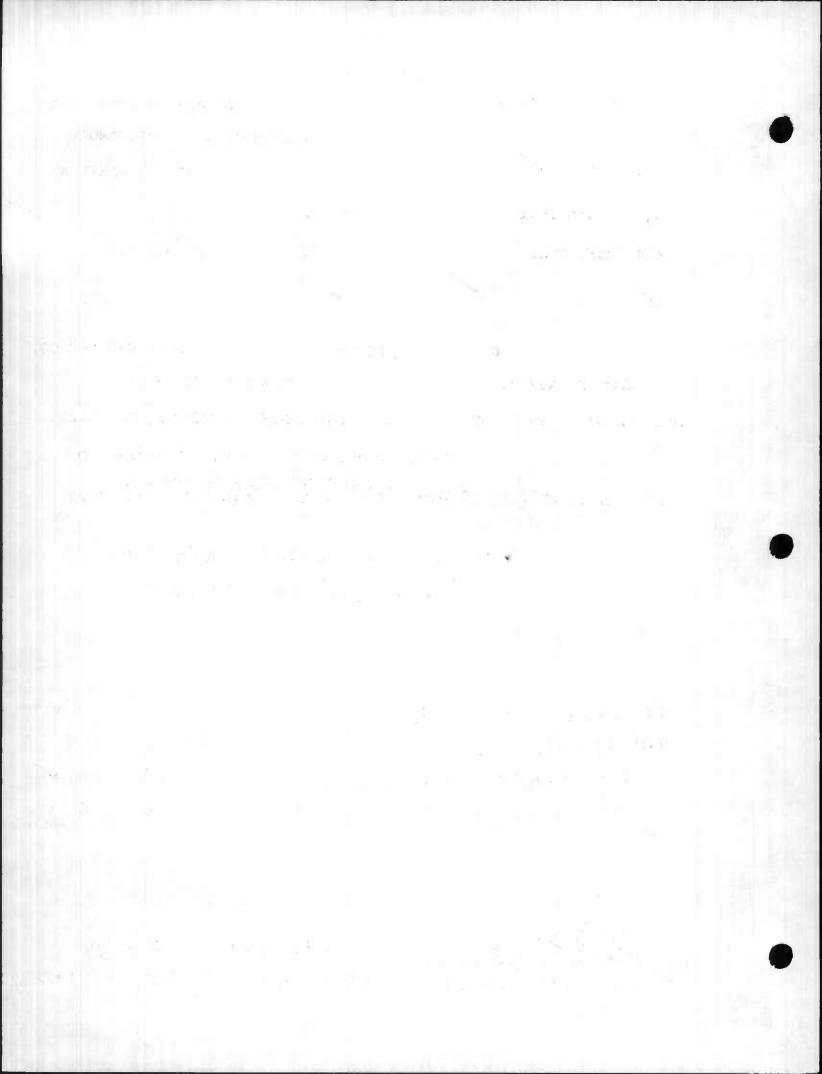
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State of Maryland / Department of Health and Mental Hygiene 9 9

							Cei	rtificate o	f Death		Reg. No.			
	Physicia	n	1. Decedent's Name (First, M GEORGE J							2. Date of D Month		Yeer	3. Time of Death	
	/Medica	ai	4a Facility Nama (If not Instit	ition, give	streat and nur	nbar)			4b. City, Town, or		th 4c. County			
1	Funeral Director	•	5. Social Security Number 212-09-4924	6. S			. last birthday)	If Under 1 Yes	ar If Undar 24 Hrs	8. Date of B		9. Birth	placa (State or Foreign ntry) YLAND	
		tor	Usual Residence of Deceden 10a. Stete 10b. Cou MD BA		ORE	10c. C	ity, Town or Lo	cation THERVI	LLE			10d. Inside City Limits		
	th with the	Funeral Director	10e. Street end Number 1420 FRONT	AVE				10f. Zip Code 21	093		10g. Citizan of U.S.		ntry?	
020	Si - Fi	۾	11. Maritel Status 1 Never Married 2 1 3 Widowed 4 Divor		Armed For 1 ☐ Yas If Yes, Giv	Vas Decedent Ever in U.S. umed Forcas? □ Yas 2 □ No Yes, Give ear or Dates:			f Hispanic Origin? (Suben, Mexican, Puer o Specify:	Specify Yas or N to Rican, etc.)		ck, White,	can Indian, etc.	
21215-0020	i within 72 hours iene. ' then "neturel', 're Moolcal Ext	Completed	15. Dece (Specify only hi Elamentary/Secondary (0-1	phest gre	ucetion de com <i>plated)</i> College (1	-4or 5+)	(Give	dent's Usuel Occ kind of work don DO NOT use reti ECHANI	ne during most of wo ired)	16b, Kind of Business/Industry				
Maryland 2	d off	o Be	17. Fether's Name (First, Mid GEORGE		FERT									
		-	19a. Informant's Name/Relet MRS. PATRIC			PS .								
Baltimore,	Department of Heelth a mportant: If item 27 is any injury or other transment.		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Otha			State	cemetery, crer	sition (Name of natory or other p HEART		Data / 3 / 9 9	20c. Location DUNDA			
Balti	pemit. Peg Department Important: It any injury o		21. Signature of Funerel Sen	ice Lican	0/4	0	1		WSKI FUN EET ST.			_	1224	
x 68760,	entificate be	Med	Immediate Causa (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avents resulting in deeth) Last	{	e. AC	Due to (or as a consactor as a consactor	quence of):	REERY			(NO)		
P.0	that the ed by th detache	/ Physician/	Part II. Other significant con			ath but not re	0	nderlying ceusa	given In Part I.		i tobacco use co	ontribute t	o the cause of death	
Records,	ew requires is been signal 2 should be	Completed by	PARKIN	50	NIS	m				24e. Wa	s an eutopsy formed?	av.	fare autopsy findings vailable prior to ompletion of cause death?	
tal Re	iclan: The law certificate hes t rector, page 2 s		SICK 25. Was cese referred to me		NUS	27	NDI	Comi	-		Yes 10 No	1	□Yas 2⊞No	
Division of Vital	hys ldi	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Deeth 1 Matural 5 Pe 2 Accident		28e. Dete d (Mont	1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H					Death (Check only one) ng Home 5 Residence 8 Mother (Specify) A SS 1 S T 28d. Describe how injury occurred			
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	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medi	cal Exam		sis of examin		vestigation, in m	tima, date and plac y opinion, daeth occ		, date end piece	, end due t	to the ceuse(s)	
	tige 6	-	29b. Signature and till of	23	29			D	156	34	29d. Dete sign	3.9	Q Tour	
	11		30. Nama and address of per	JEE !	TUN	of death (Ita	m 23a) (Type,	Print) 341	BAN	K ST.	BAL	TO	MD2122	

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Registrar



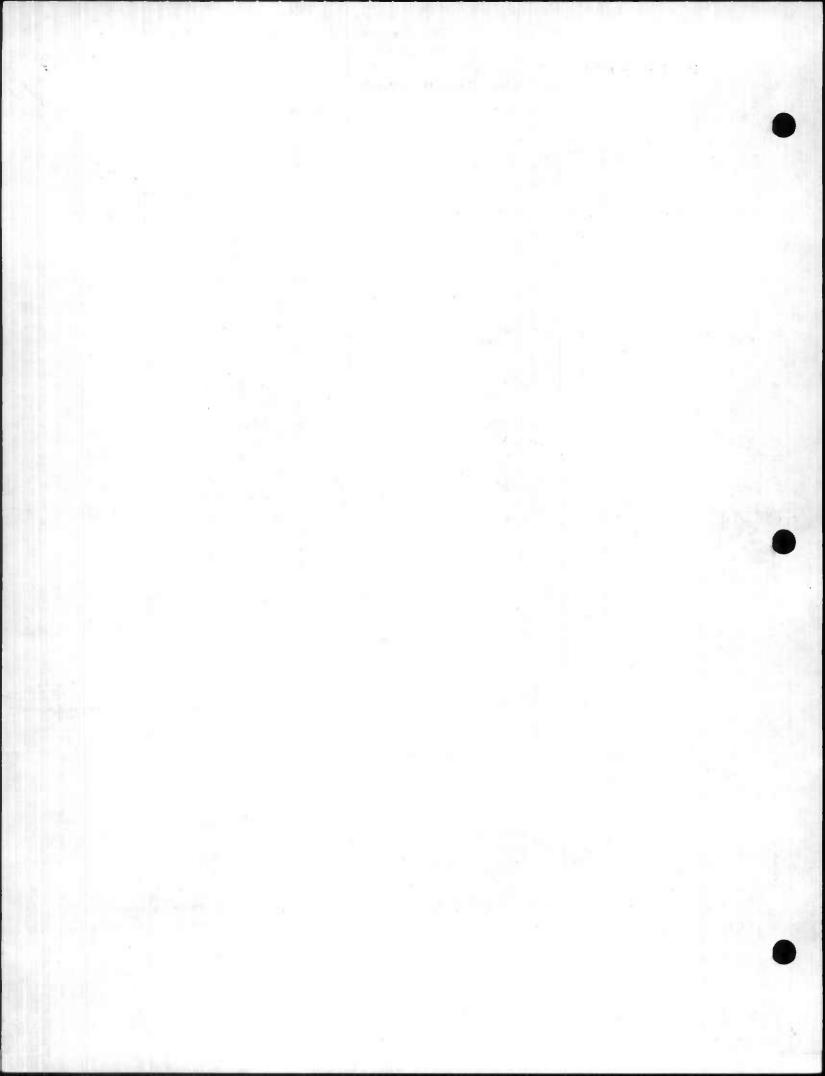
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State of Maryland / Department of Health and Mental Hygiene Item 1 Per PHY FilmG768 2-4-99 rja Certificate of Death Helene Elizabeth MC Donald 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 22, 1999 1 MCDONACD , SISTER 3:35 AM HELENE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6806 Bellona Avenue Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2₩F 72 220-18-5070 Yrs. Director June 28, 1926 Maryland Usual Residence of Decedent the Meryland 10s. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Merylen Hyglens, but than "natural", or fleme 23a or 28a-f ehow ent, the Medical East inc. med the notified as 10d. Inside City Limits Baltimore City Maryland Baltimore 1 □XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 Bellona Avenue 21212 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Bleck, White, etc. 1X Never Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mission Helper Religious i. Pages 1 and 2 should be filed w tment of Health end Mental Hygler tant: If Nem 27 Ia marked other th ilury or other traumatic event, the Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Francis McDonald Florence Irene Carrigan 19b. Meiling Address (Street and Number or Rurat Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Edward McDonald/brother 113 Collins Avenue, Catonsville, Maryland 21229 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If any Injury or once. 4 Donation 5 Other (Specify) 21. Signature of Fundal Se ²² Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street S. Wade Director rece Baltimore, Maryland 21201 Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart lailure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examine 0116 physicien end the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 2 vomosba Box 68760, Physician/Medical Due to (or as a consequence of): 88 480 for P.O. detached 23h. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed b Records. P 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Certification: To Be Completed 24a. Was an autopsy performed? After this certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 55 Residence 6 Other (Specify) 1 Yes 2 No funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Division Matural 5 Pending investigation 1 Yes /2 No within 24 hours efter death. To the Funerel Director: A 2 Accident the 6 Could not be 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, lerm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. edical 29a. Certifier completely (Check only 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (It 3 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

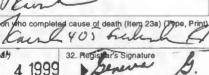
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Defe of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** :00 a.m. 4b. City, Town, or Location of Death ason ar /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday)
Yrs. 9. Birthplace (State or Foreign 1 M 2 F Months Devs Hours Min Yrs. Director Usual Residence of Decedent 72 hours after deeth with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or flams 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Baltimore 1 Was 2 No Director 10g. Citizen of Whet Country? Street and Number Son by Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: American Indian, 11. Merifal Stefus Black, White, etc. 1 □ Never Married 2 □ Married 1□ Yes 2♥ No Baltimore, Maryland 21215-0020 Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filled within 72. Department of Health and Mental Hygiene important if fleen 27 is merental Hygiene. dary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumeme) Be City or Town, Stete, Zip Code) 20c. Location - City or, Town, State 1 M Burial 2 Craffi 4 Donation 5. Other (Specify) 21. Signature of Fugeral Sec Approximate Interval Between Onsef end Death **Physician** esst loncer Immediate Cause (Finet disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Physiclan/Medical Examiner physician end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, that the death certificate be Due to (or as a consequence of): 88 for use 23b. Did tobacco use contribute to the cause of death? signed by the a d be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: director. 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient After this funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury af Work? 28a. Date of Injury (Month, Day Year) 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

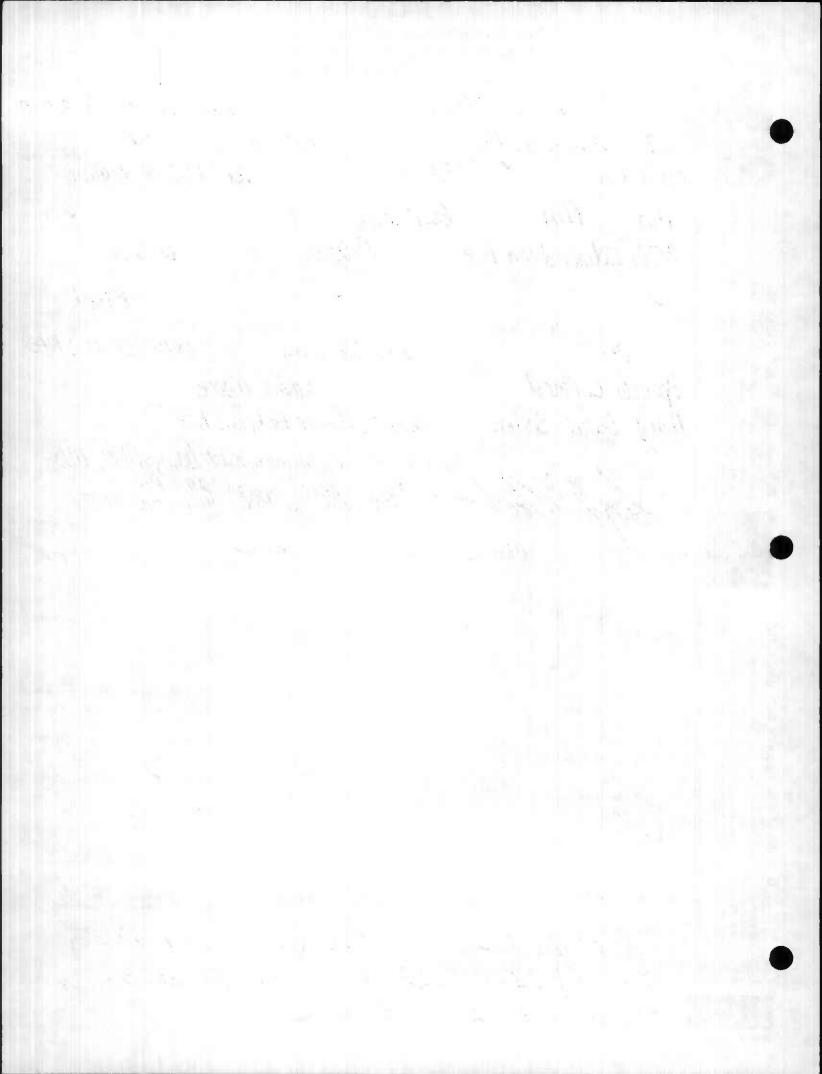
State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1 Decedent's Nama (First Middle Last) Month Yaai **Physician** February 2 300 PM 19991 Faye V. Michelson /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Sinai Mospital Baltimore N/A If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** 1□M 2₩F 88 Yrs Director Oct 10, 1910 Maine 010-36-1370 Usual Rasidence of Dacedant 10b. County 10a. Stata 10c. City. Town or Location 10d. Instda City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Vas 2 □ No Director Maryland N/A Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code Funeral U.S.A 119 West Northern Parkway 21210 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian Black, Whita, atc. 2 should be filed within 72 hours after n and Mental Hygiene. Is marked other than "natural" or its 1 Yas 2 No If Yas, Giva X Yaar or Datas: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) Lynn, Massachusetts Etamantary/Secondary (0-12) Coilega (1-4or 5+) Public School Sys 5+ Teacher 18. Mothar's Nama (First, Middla, Meidan Sumama) 17. Fathar's Nama (First, Middla, Last) Woodward Maude Bryant Charles E. 19a. Informant's Name/Ratationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Health a Important: if item 27 is any injury or other training. 1010 Winding Way, Baltimore, Maryland 21210 Janet Rosen (Daughter) 20b. Place of Disposition (Nama of cematary, cramatory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 2/5/99 Peabody, Massachusetts Puritan Lawn Mem. Park 21. Signatura of Funaral Sarvice Licansas 22. Nama and Addrass of Facility A. Alan Seitz, Jr. Funeral Home 23a. Part 1. Entar the disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac of respiratory arrest, Approximate Approximate **Physician** Immedieta Ceuse (Finel disaasa or condition resulting In death) /Medical Examiner Dua to (or as consequence of) Examiner HTN Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Ceuse (Disaase or Injury that initiated avants Dua to (or as a consequanca of) Physician/Medical as the Dua to (or as a consequance of): rasulting in daath) Last USB ō Part II. Other significant conditions contributing to death but not resulting in the underlying cause given to Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 ☐ No funeral director, 25. Wes case ratarred to medicel examinar? Be 26. Piece of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Rasidenca 6 Othar (Specify) Certification: To 28a. Data of Injury (Month, Day Year) 28c. fnjury at Work? 28d. Dascribe how Injury occurred 27. Manpar of Death 1 Neturel 2 Accidant 5 Pending Invastigation after death. Director: Aft 1 Yas 2 No 281. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datermined 3 Suicida 28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 29a, Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical

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Division of Vital Records, P.O. Box 68769,

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altimore, Maryland 21215-0020

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February 2, 1999

29d. Data signed (Month, Day, Year)

30. Nama and eddress of person who completed causa of daath (Item 23a) (Type, Print)

Dr. Choi, Sinai Hospital, 2401 W. Belvedere Ave., Baltimore, Maryland 21215

29c. Licansa number

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31. Data filed (Month, Dey, Year) State

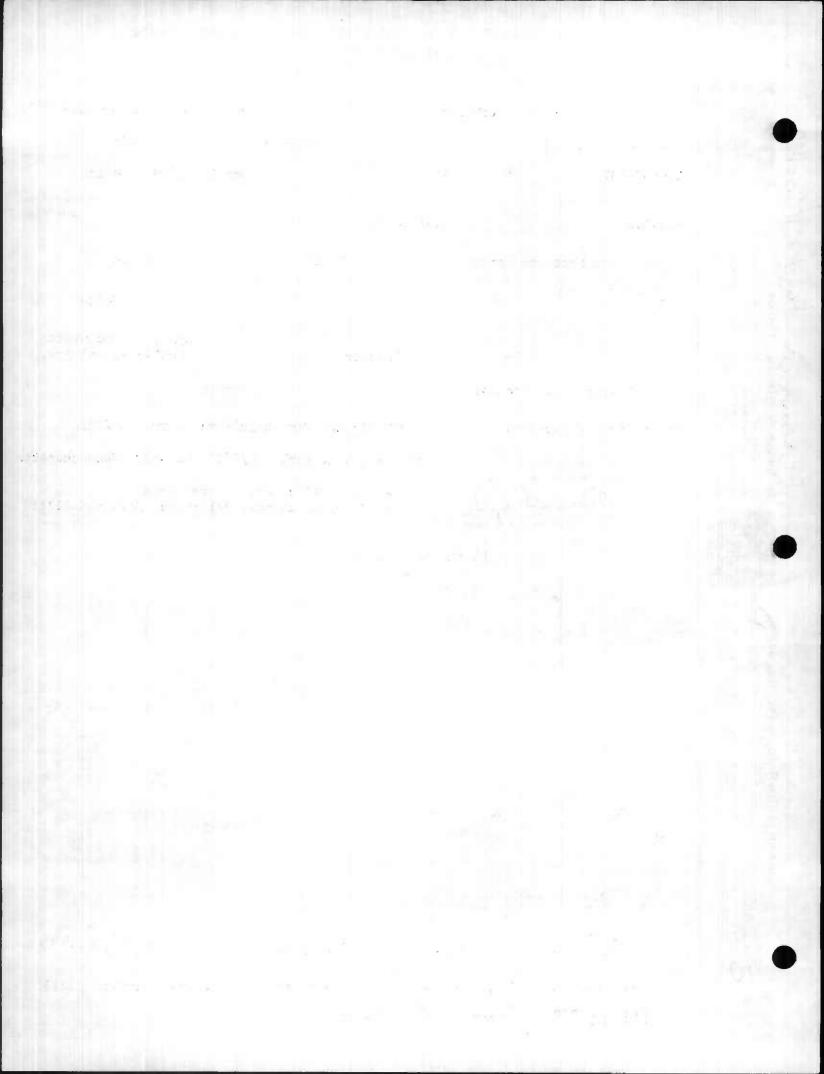
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29b. Signatura and titte of certifie

32. Registrar's Signature

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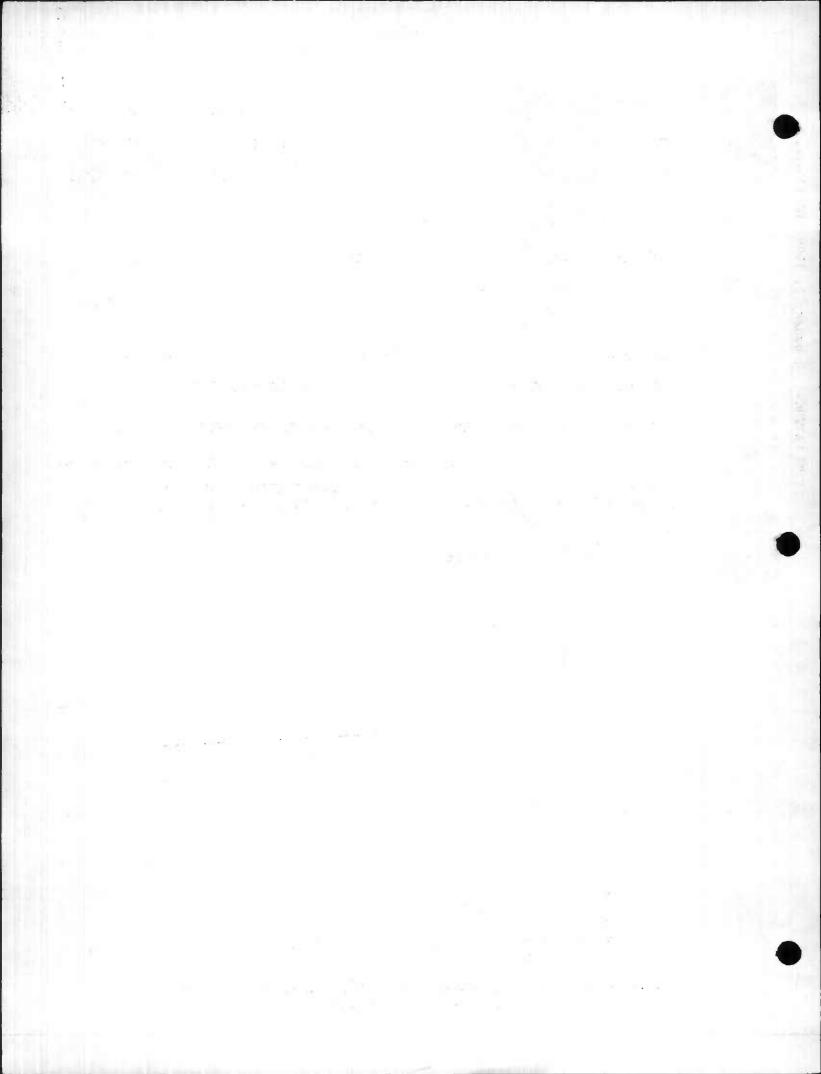
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	STELLA MARIS						TIMONIUM			TIMORE		
	5. Social Security Number 212–07–6769			Aga (In yrs. 81	last birthday) Yrs.	Months Days		8. Data of Birth (Month, Day 1/3/18	r, Year)	9. Birthplac Country) MARYL		Foreign
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	30. Name and address of per	son who co	ompleted cause of	death (Ite/	n 23a) (Type,	Print)				•		
	DR. TARIQ MA	HMOOI	2300 1	OULANI strar's Signe	EY VALL	EY RD.	TIMONIUM,	MD 210	93			
	edical Certification: To Be Completed by Physician/Medical Examin	Usual Residence of Deceder 10a. State 10b. Co MD BAL 10e. Street and Number 3520 HISS AV 11. Marital Status 1 Nevar Married 2 15. Dece (Specify only h.) Elementary/Secondary (O-8th GRADE 17. Father's Neme (First, Mid.) LAWRENCE J. 19a. Informent's Name/Relat HELEN M. WII. 20a. Method of Disposition 1 Sequential 2 Cremat 4 Donation) 5 Othe 21. Signety of uneral San 23a. Piret Inter the disease of heart failure. Immediate Cause (Final disease or conditions are withing in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other significant con 25. Was case referred to mere auminer? 1 Yas 2 No 27. Menner of Deeth 1 Nother significant con 29a. Certifier (Check only one) 29b. Signature and this or ber 30. Name and address of per 30. Name and address of per 30. Name and address of per	Usual Residence of Decedent 10a. State 10b. County MD BALTIMOR 3520 HISS AVENUE 11. Marital Status 1 Nevar Married 2 Married 3X Widowed 4 Divorced (Specify only highest grad Elementary/Secondary (0-12) 8th GRADE 17. Father's Name (First, Middle, Last) 128. Informent's Name/Relationship (7) HELEN M. WILLE 20a. Method of Disposition 1 XBurial 2 Cremation 3 F 4 Donation) 5 Other (Specify) 21. Signett's cultureral Sarvice Licens 23a. Plant Enter the disease, or complete the disease of condition resulting in death) Sequentially list conditions, if any, laading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, laading to immediate cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other significant conditions conditions of the conditions of the condition of the	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORE 10c. Street and Number 3520 HISS AVENUE 11. Marital Status 1	Usual Residence of Decedent 10a. State 10b. County 10c. Cit MD BALTIMORE 10c. Cit MD BALTIMORE 10c. Street and Number 3520 HISS AVENUE 11. Marital Status 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under Armed Forcas? 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5+) 12. Was Decedant Evair in Under College (1-4or 5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	Usual Pacietone of Decedent 10s. State 10b. County 10c. City, Town or Location PARKVILLE 10b. State 10b. County 10c. City, Town or Location PARKVILLE 10c. Street and Number 10s. State 10b. County 10c. City, Town or Location PARKVILLE 10c. Street and Number 10s. State 10c. County 10c. City, Town or Location PARKVILLE 11c. Number 10s. State	Light Ligh	Table Tabl	The comment of the part of the comment of the com	1/2 1/2	Table Tabl



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Lo 17/8 12:30pm Tunuary 1 ay Fre /Medical 4a Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultmore 1. Bultmo Bultmore HOSPIT 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Days 1 □ M 2 Ø F Months South Carolina Yrs. June 4, Director 219-18-2332 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "natural", or items 23 or 28=1 show any injury or other traumatic event, the Medical Examinat must be notified at an obdes. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland N/A Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4109 Chesterfield Avenue 21213 U. S. A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Albert Mobley Elijah Garvin 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3325 Elmley Avenue, Baltimore, Maryland 21213 Shirley Horton (Niece) 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/6/99 Baltimore, Maryland Arbutus Memorial 22. Name and Address of Facility
Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland 21213 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner physicien and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): P.O. Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): 98 attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Division of Vital Records, þ been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has page 2 1NO 1 Yes 22 No 1 Yes certificate To the Hospital or Attending Physicien: director, 25. Wes case referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 After this 27. Manne of Death 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1. Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: / 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral Complataly filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number

State

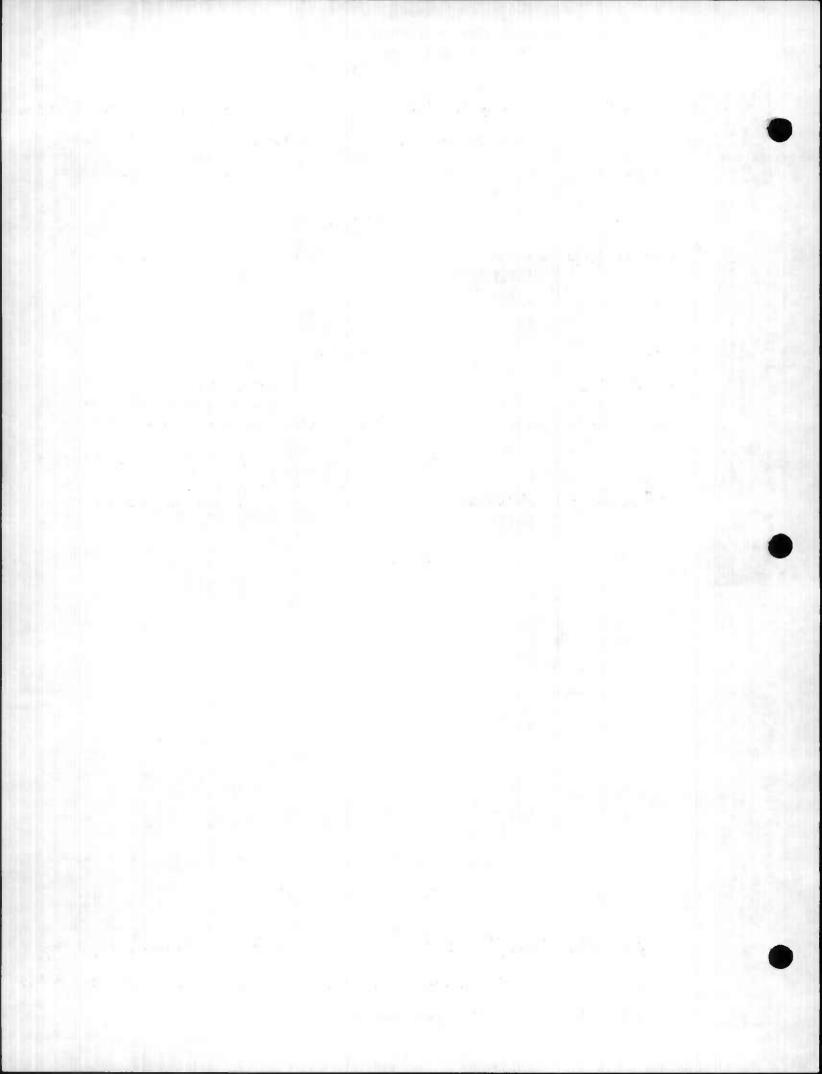
Registrar

Jonathan 31. Date filed (Month, Dey, Year) FEB 0 4 1999

29b. Signature and title of certifier

5601 Loch-Ruver Boulevard, Bultimore, mg. 21239 32. Registrer's Signeture

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)



RKD 99-0520-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene THOMAS 27, 28A-F PER MEO CErtificate of Death ITEMS: #23 PART I, II, NICHOLSON 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician JANUARY** 31, 1999 7:40P.M. Thomas James Nicholson /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** BALTIMORE UNION MEMORIAL HOSPITAL N/AIf Under 1 Year If Undar 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Yrs. Director 216-68-6755 42 Nov 10, 1956 Maryland Usual Residence of Decedent with the Marylend r 28a-f show 10e, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ♥ Yes 2 No N/A Baltimore Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? "natural", or items 23s or permit. Pages 1 and 2 should be filed within 72 hours effer death a Department of Health end Mental Hygiere. Important: If Itam 27 is marked other than "natural; or Itama 23a any Injury or other traumatic avent, the Modes Examines manner. 511 East 25th Street 21218 U.S.A Funeral

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Physician /Medical

Examiner

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after death Director: A

death.

director,

Examiner

Physician/Medical

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Completed

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Certification:

edicai

12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

College (1-4or 5+)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yes 2 ♥ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed) Etementary/Secondary (0-12) 9

1 Never Married 2 Married

3 Widowed 4 Divorcad

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roofer

Self-employed

16b. Kind of Business/Industry

17. Fether's Name (First, Middle, Lest)

Lewis Shelton Nicholson

Hazel Carpenter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

19a. Informent's Name/Relationship (Type, Print) Mary Goodman (Sister) 20a. Method of Disposition

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

8219 Dundalk Avenue, Baltimore, Maryland 21222 20c. Location - City or Town, Stete Date

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

Green Mount Cemetery 22. Name end Address of Fecility 2/5/99 Baltimore, Maryland

21. Signature of Funeral Service Licenses

A. Alan Seitz, Jr. Funeral Home

3818 Roland Avenue, Baltimore, Maryland 21211 that paused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, and hine. Approximate Interval Between Onset and Death

18. Mother's Name (First, Middle, Meiden Sumeme)

Immediate Cause (Final disease or condition resulting in death)

NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Last

Due to (or as a consequence of):

Dua to (or as a consequanca of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

HEPATIC CIRRHOSIS

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to compiation of cause of death?

1 Nas 2 No

1€ Yes 2 No

25. Wes case referred to medicat examiner? 1⊠ Yes 2□ No

Hospital: 1 ☐ Inpatient 200€R/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 5 Pending UNKNOWN investigetion

28b. Time of UNKNOWN 28c. Injury et Work? 1 ☐ Yes 2 ☑ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

UNKNOWN 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

26. Plece of Deeth (Check only one)

6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNKNOWN

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as steted.

29a. Certifier

27. Menner of Deeth

1 Naturel

2 Accident

3 Suicida

4 Homicide

25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. Licansa number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

O.C.M.E.

FEBRUARY 1,1999

of person who completed cause of deeth (Item 23e) (Type, Print)

Joseph PRS taner 31. Date filed (Month, Dey; Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 32. Registral's Signature

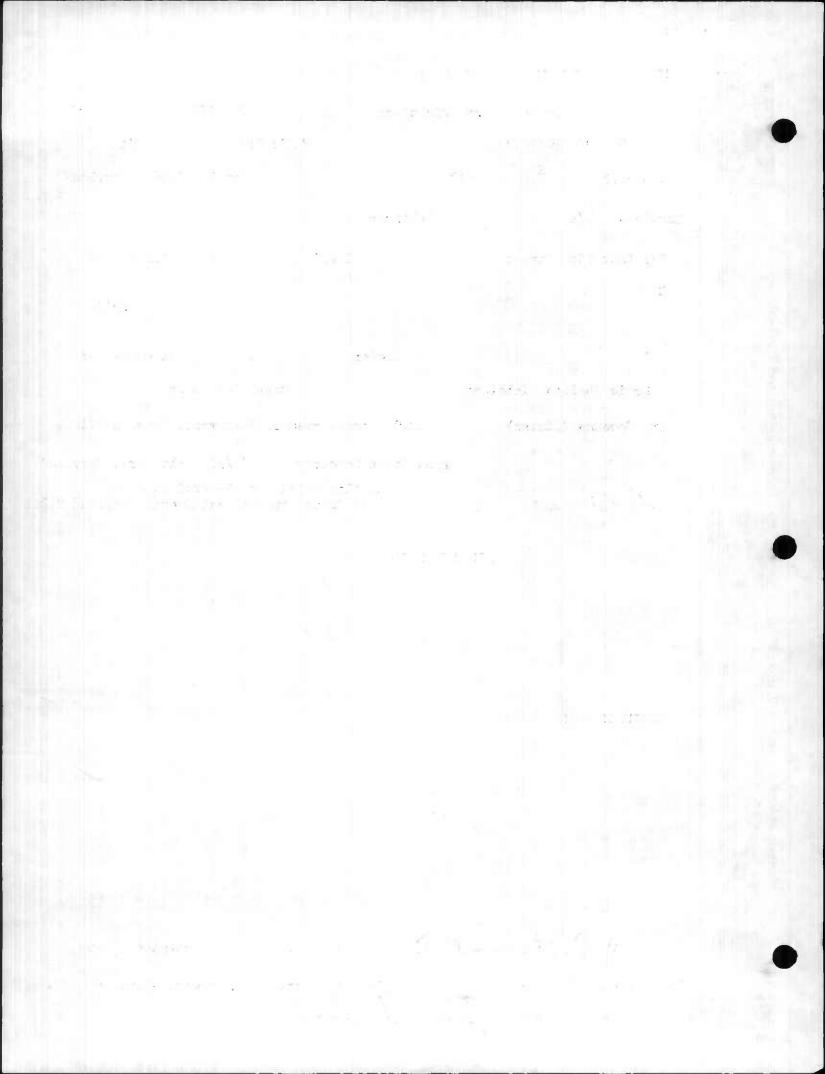
DHMH 16 Rav 6/95

Division of Vital Records, P.O. Box 68760,

or Attanding Physician:

The law requires that the deeth certificate be executed

To the Hospital or within 24 hours aft To the Funeral Di completely filled in



Examiner P.O. Box 68760. Records,

The law requires that the death certificate be executed the 99 page 2 certificate Division of Vital Hospital or Attending Physicien: funeral After illed in by completely

Physician

/Medical

Examiner

Director

Funeral

Completed by

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or other tree

permit. Pege Depertment of Important: If eny injury or once.

Physician

/Medical

Examiner

the Maryland

death

Peges 1 end 2 should be filed within 72 hours efter in of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

Physician/Medical Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. by Completed Be 25. Wes cese referred to medical 1 Yas 2 No Certification: To 27. Manner of Deeth 1 Pflaturei 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier Medical 29b. Signeture and title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number

- KeistNAN 31. Dete filed (Month, Day, Year)

221 MD 32. Registra 's Signature

4 1999

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

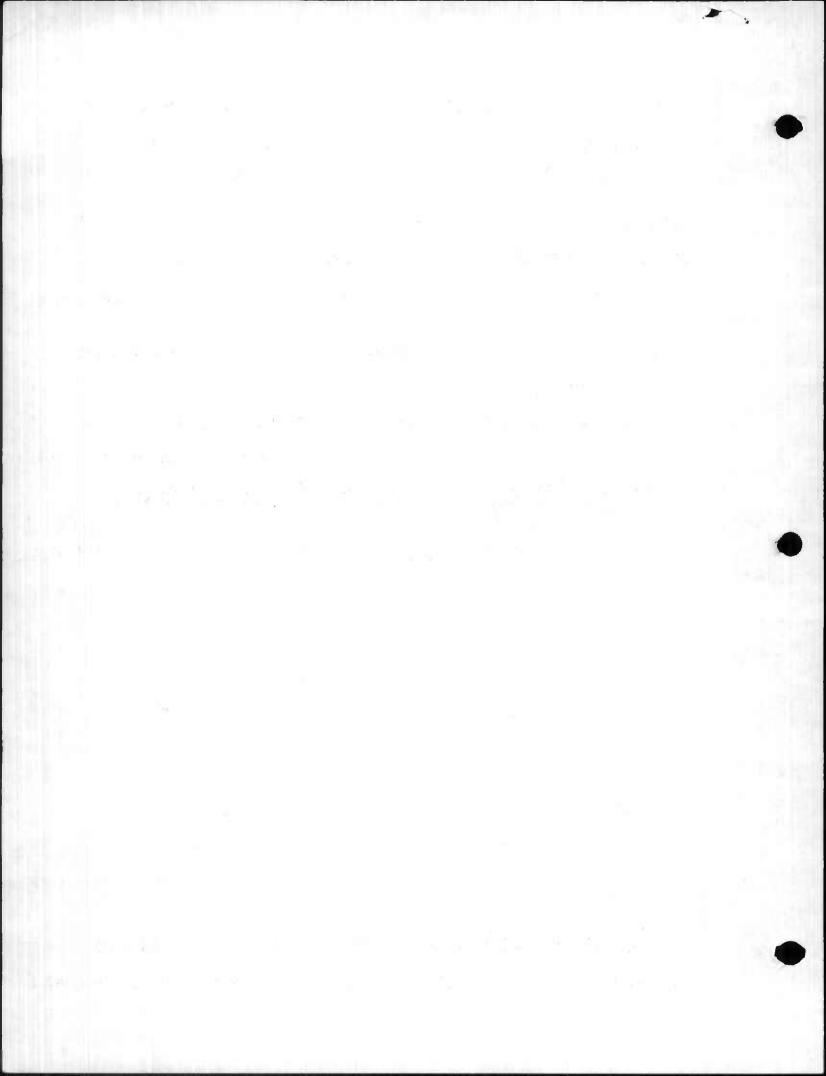
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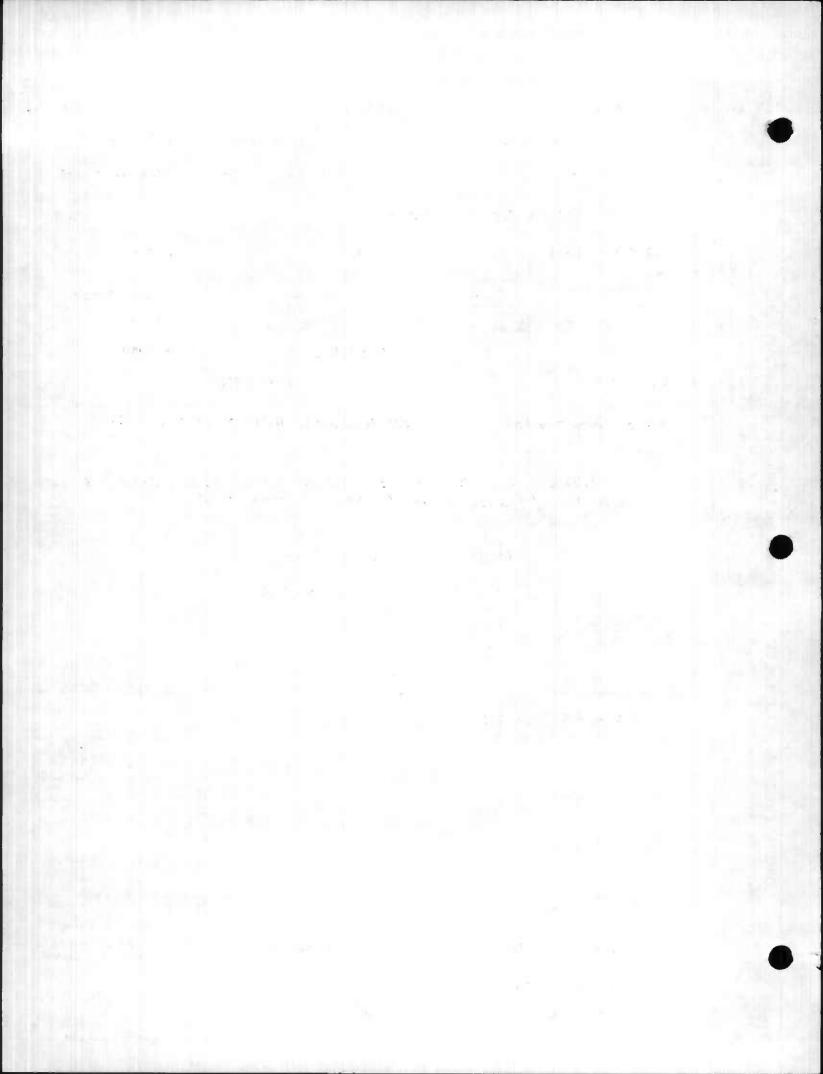
State

Registrar



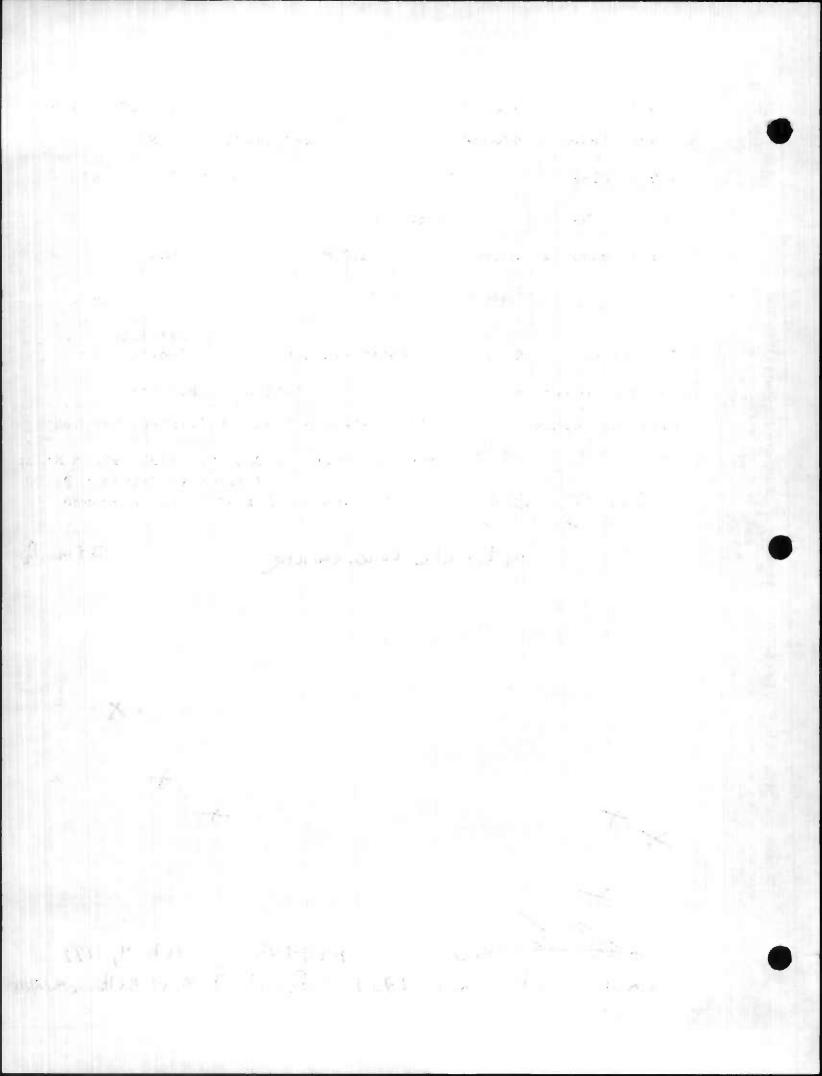
State of Maryland / Department of Health and Mental Hygiene

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aminer	4a Fa	cility Nema (If not institution, given	va street and numb	er)				4b. City, To	wn, or Lo	cation of Deat	h 4c. Co	unty of I	Death	
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ral or	21.	5-14-8768	Sax 1 M 2 F	Age (In yrs.	last birthday) Yrs.	if Und Months	ar 1 Yaar s Days	If Under: Hours	24 Hrs. Min.	8. Deta of Bi (Month, Di Dec.	rth a <i>y, Yaer)</i> 1, 192	9	Birthplaca (S Country) Maryla	
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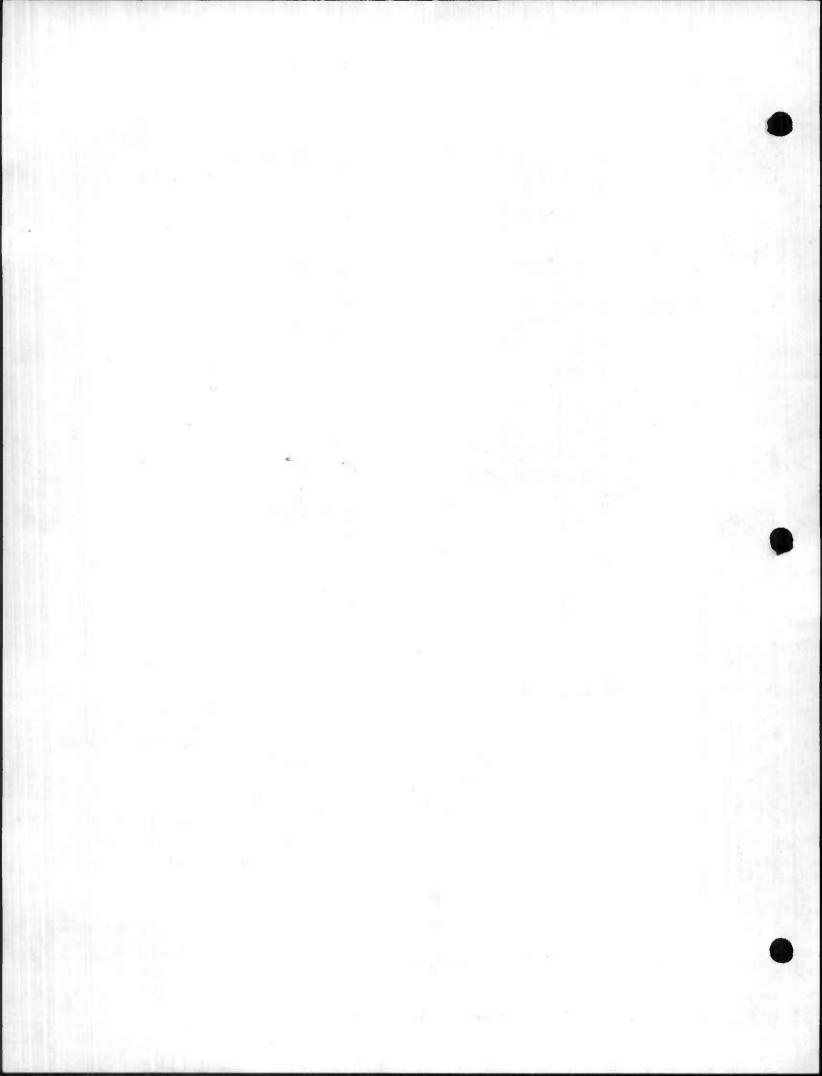
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** acy Overmier 11:15 January /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Chesapeake Hospice House Anne Arundel Linthicum 7. Age (In yrs. last birthday) If Under 1 Yeer | Months Deys 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 10 M 20F Hours 82 Yrs. Director 577-01-8044 October 9,1916 Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pagas 1 and 2 should be filed within 72 hours after death with the Manyan nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or flems 23s or 28s-f show int: If them 27 is marked other than "natural", or other traumatic event, the Majoral Environment man be notified. XX Yes 2 □ No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5800 N.W. Crain Hwy. 20715 Funeral Prince George's 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Menitel Stetus 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: White by 3 d Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Joseph Webster Owens Mary Ellen Wise 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5804 N.W. Crain Hwy. permit. Pages 1 and Department of Health Important: If Nem 27 any Injury or other tr once. Beverly L. Oliver/daughter Bowie, MD 20715 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cemetery2/4/99 Cheltenham, MD 22. Name and Address of Fecility 21. Signature of Eurorel Service Licensee Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie, MD 20715 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Finel re Colon Cancer to Liver TUS disease or condition resulting in deeth) Examine Examiner or Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): The law requires that the death certificate be axe Box 68760. Physician/Medicai Due to (or es e consequence of) signed by the sid P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? pege 2 1 Yes 2 No 1 ☐ Yes 2 No certificate or Attending Physician: director. Be 25. Was case referred to medical examiner? Chesapeuke 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice House 1 Yes 2€No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Neturel 5 Pending 1 Yes 2 No Investigation 24 hours after death Funeral Director: A 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as steted.

| Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30-Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Kussella, , glady Shity bor, GlenBurm Deluca 600 1410 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Dav Yaar JOE WARREN PRICE 29, 1999 3:30am JANUARY 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) N/A BALTIMORE FUTURE CARE SAND TOWN WINCHESTER NURSING HOME 8. Date of Birth (Month, Day, Year) 8-1-58 Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex ↑ M 2 F 7. Age (In yrs. last birthday) Days Hours 219-66-6066 40 MD Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1412 N. BOND ST. 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2½ No tt Yes, Give** Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Biack, White, etc. Never Married 2 Married Specify:BLACK 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) JOHN SMITH HELEN PRICE 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 1412 N. BOND ST. BALTIMORE, HELEN PRICE (MOTHER) MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Date 1 Burial 2 Cremation 3 Removal from State MD. NATIONAL MEM. PARK 2-3-99 LAUREL, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 1721-27 N. MONROE ST. BALTIMORE, MD 21217 CFSP xucta erecta 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate interval Between Onset and Death Acquired Immunodyimen of dime Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Dua to (or as a consequence ot): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 Yes 2 No 24b. Were autopsy tindings aveilable prior to 24a. Was en eutopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menper of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28b. Time of 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, straat, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. Licansa numbar

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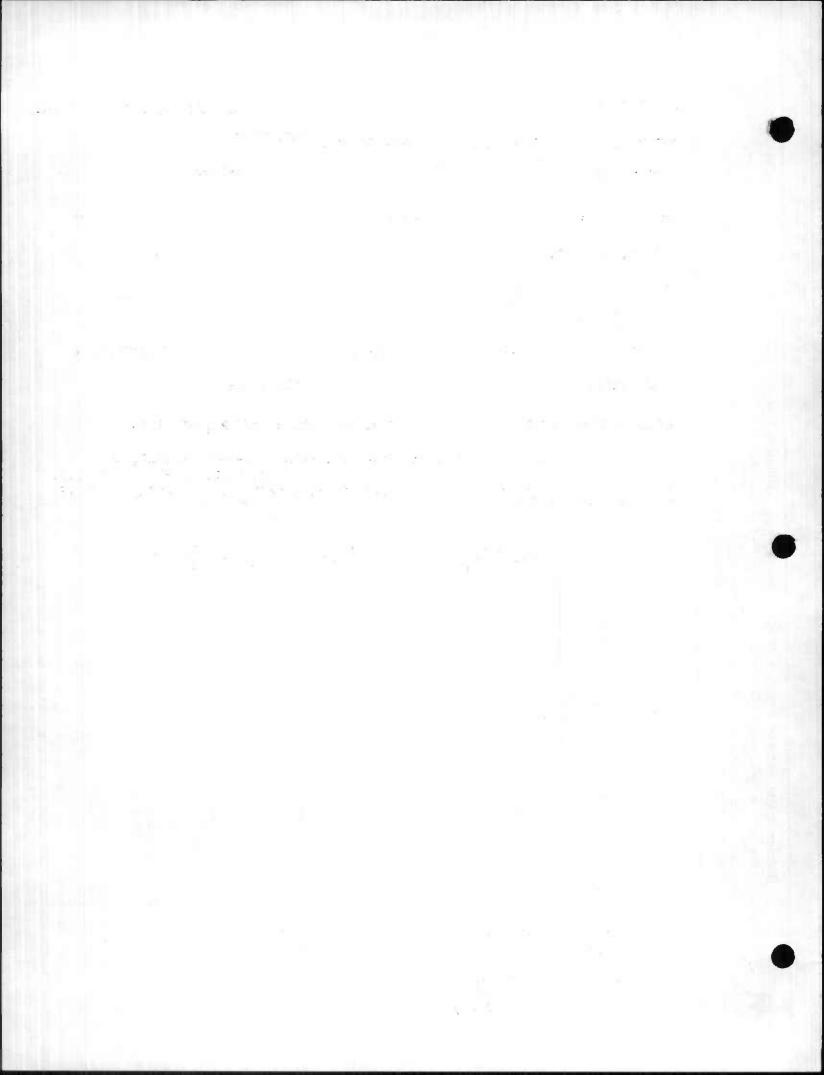
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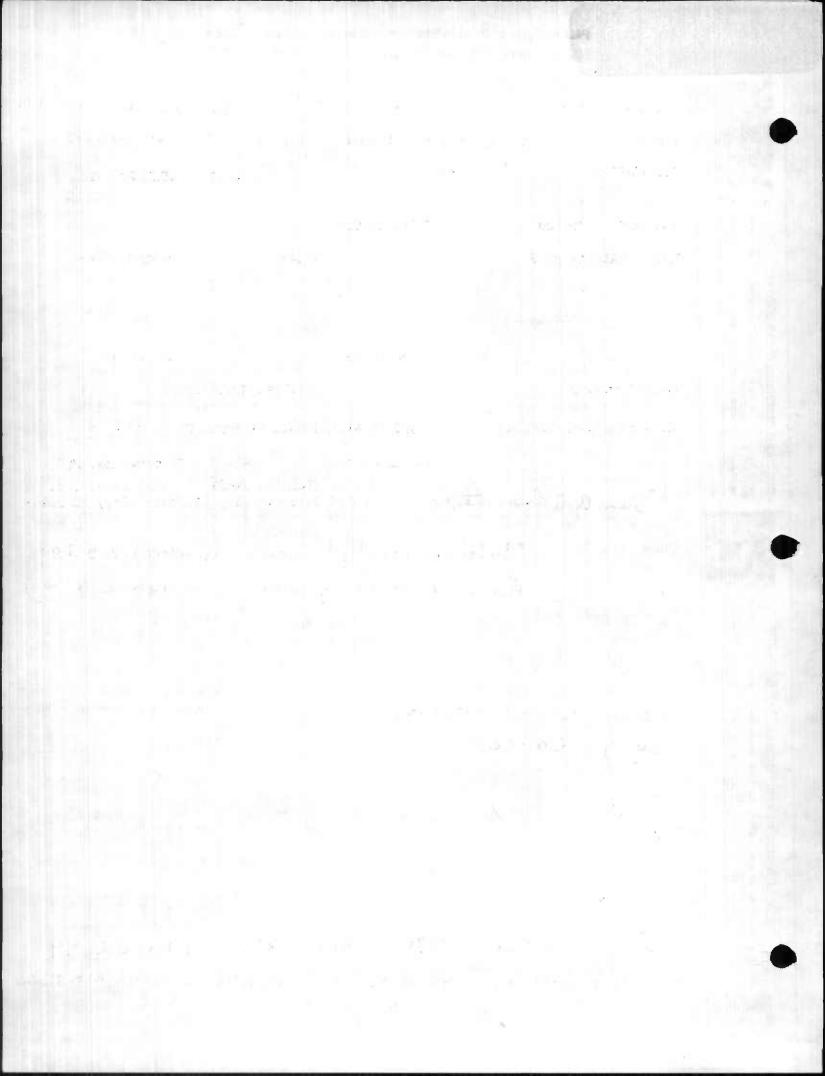
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30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) W. MOUNT Royal Auc, Galto 21217



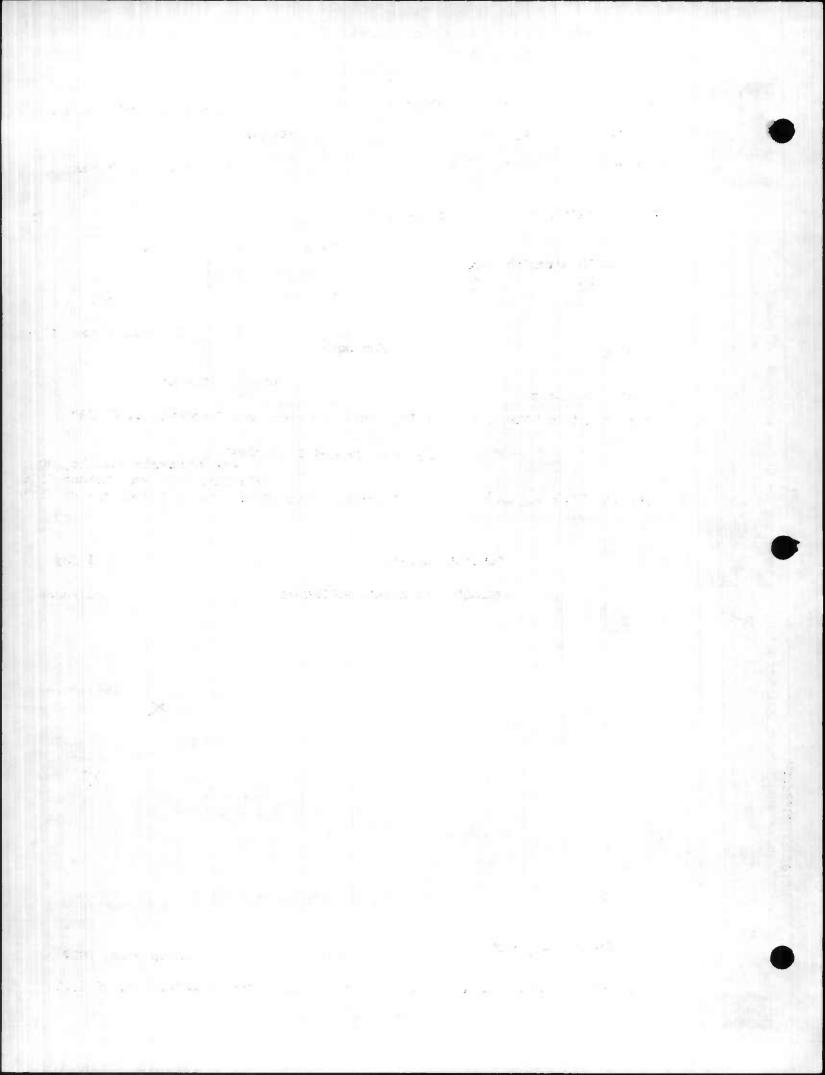
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 0330 RIVERS 99 REV. WILLIAM Feb 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) BALTIMORE N/A HEALTHCARE CENTER HARBORSIDE 8. Date of Birth (Month, Day, Year) MARCH 1, 1910 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 10XM 20 F SOUTH CAROLINA 88 Yrs. 240-01-5324 Usual Residence of Deceden 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MARYLAND BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21216 3115 PRESBURG STREET. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2V No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: AFRO.AMERICAN 3 □XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) CHURCH MINISTER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DAVIS KATHERN **JERRY** RIVERS 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1263 E. NORTH AVE, BALTIMORE, MARYLAND REV. JAMES CARTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2/6/99 ARBUTUS, MD. ARBUTUS MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ESTEP BROTHERS FUNERAL SER, P.A. ESTE LLOYD MO Mr. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 7 POUR Due to (or as a consequence of) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 725 Unknown Severe 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: Other:

ABS Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Box 68760 requires that the death certificate be Division of Vital Records. Attending Physician: Mospital or Attending 24 hours after death.

Funeral Director: After the fundation of the f To the To the To the

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State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

ZIDEV 7220 Mb 32. Registra s Signature 4 1999 FEB

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

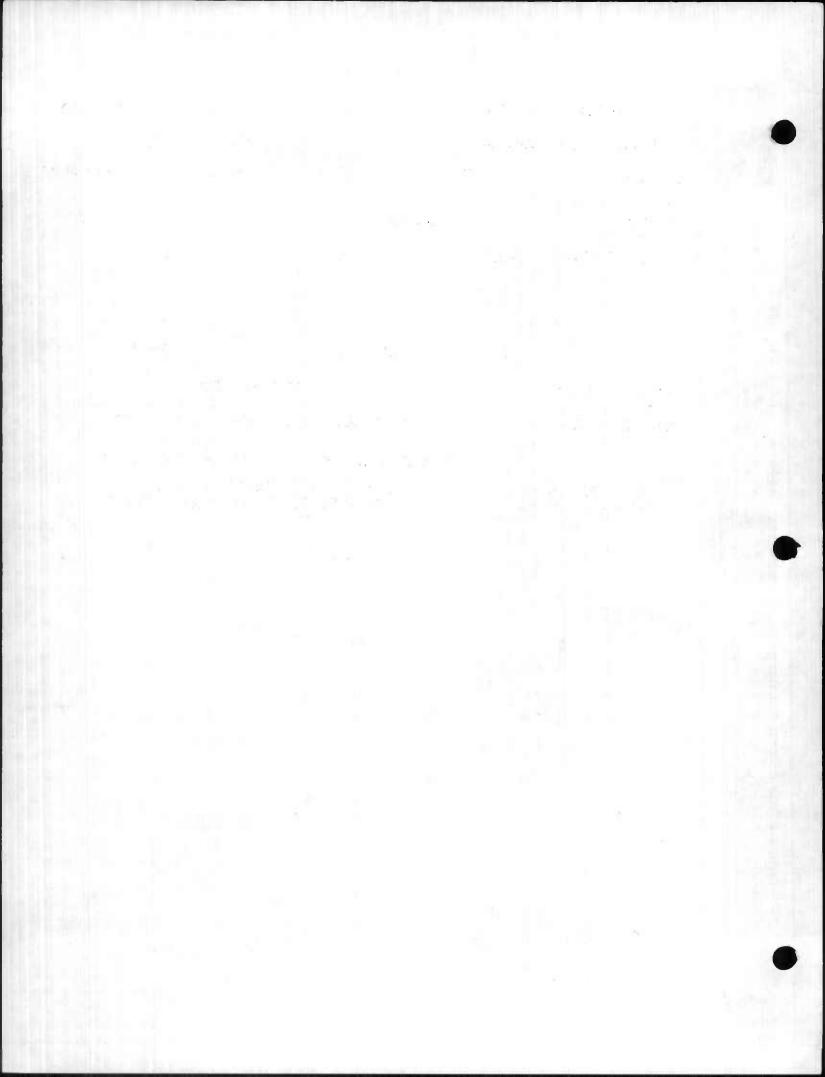
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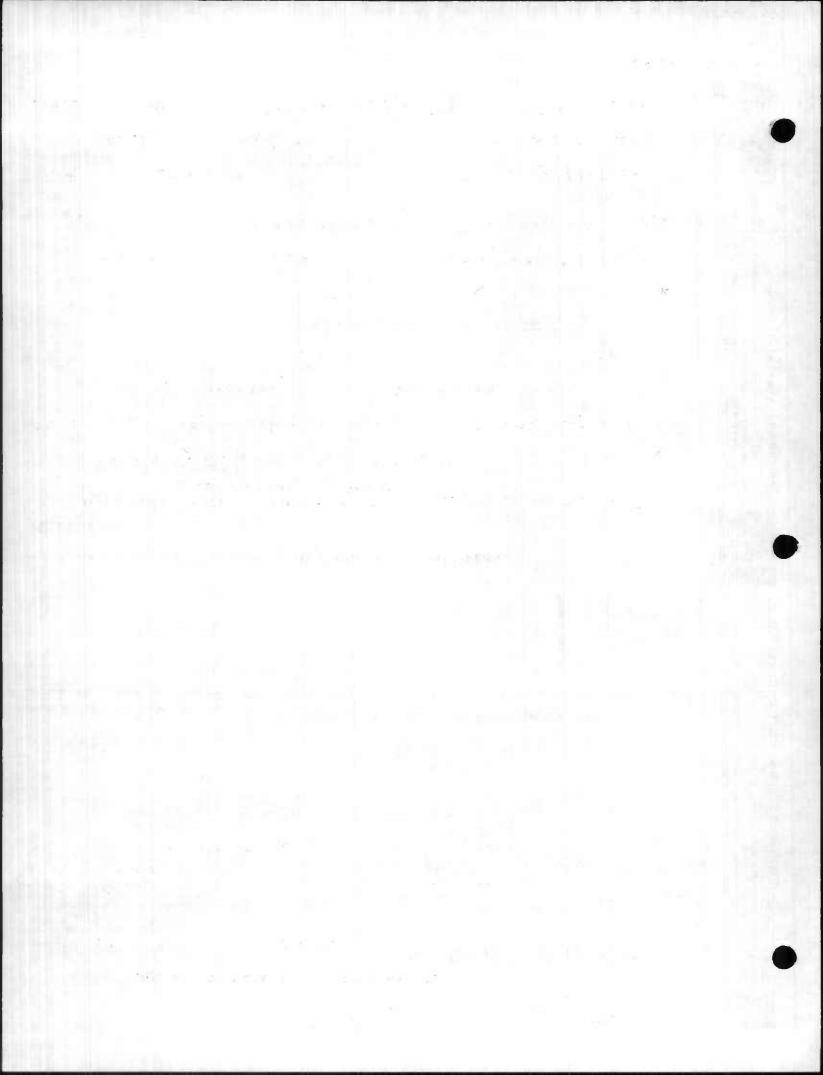
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29d. Date signed (Month, Day, Year)

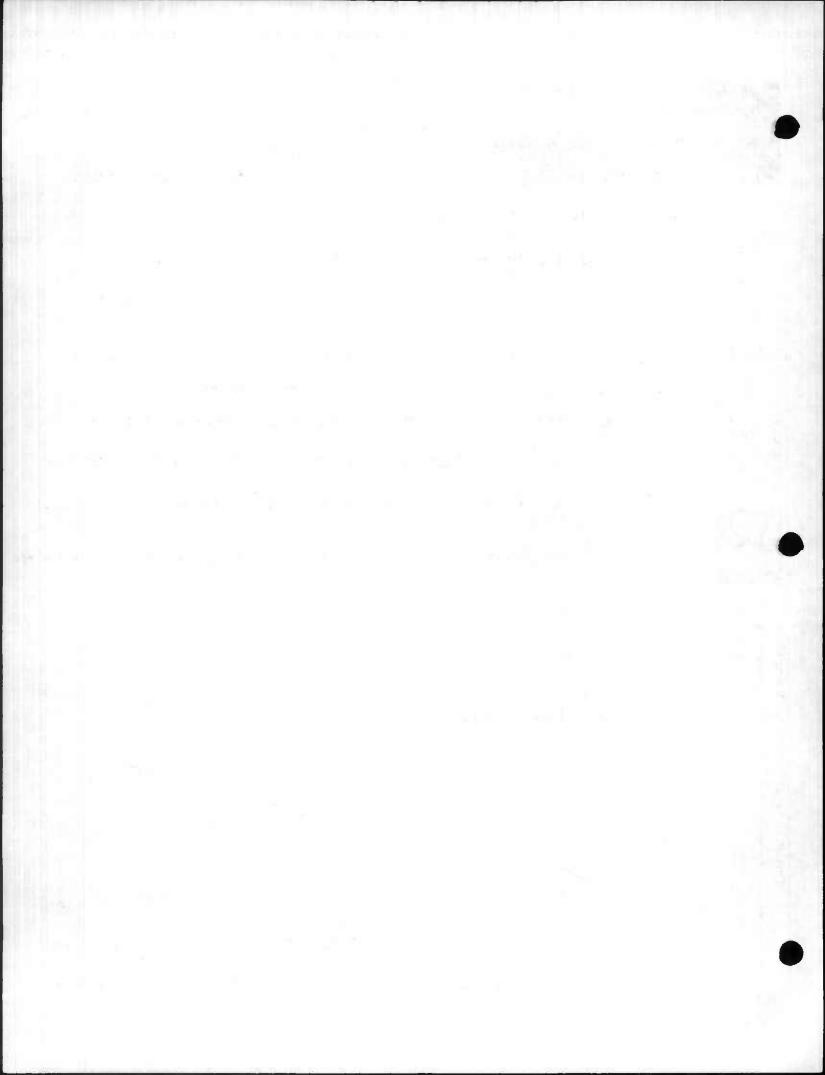
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1 21215-0020 led within 72 hours ef bygiene. Ner than "natural", or nt, the Medical Exam Completed by F	15. Decedant's Educ (Specify only highest grade		16a. Decedent's Usual Occu (Give kind of work done lifa. DO NOT usa retire	during most of working d)	9 16	b. Kind of Bush	nass/Industry
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Baltim permit. Pa Department important: any injury.	4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	MT.	ZION BAPTIST C 22 Name and Addr James A	ess of Fecility MORTO	ir Son	5	INN, S.C.
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To the Within Common Common M	Alish 1	Nac	lemo 0	.C.M.E		FEB. 4,	(Month, Day, Year) 1999
State	D4 Date Glad (Mint Day March	mplated causa of death (Item adentz 32. Registrar's Signa		, Baltimore	e, Manylan	d 21201	



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William Simms (Son) 20a. Method of Disposition 1	F						19h Mailin	n Address (Street				or Tours Ste	to Zin C	ada)
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	edical Certification: To Be Completed by Physician/Medical	2 2	shock, or heart failure. Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, ferry, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in death) Last Part II. Other eignificant con Cause (Disease or Injury thet Initiated events resulting in death) Last Part II. Other eignificant con examiner? 1	ditione co	b. c. d. Hospital: 1 28a. Date (Mor Mor) 28e. Pleocobuild yelclan: To the binar: On the binar: On the binar: On the binar in the send man	Due to Due to	ath. Do not enter (or as a consequence of the cons	B818 Role or the mode of dyli Luenca of):	ven In Part I. 26. Plece of ther: 4 Nursi rk? IYes 2 No	Palacor respirator Conductor 23b. I 24a. V Palacor respirator 23b. I 24a. V 24a. V 28d. Descr 28f. Locatil City or lece, and due to occurred at the time	Did tobacco I Yes 2 Was an autoperformed? Yes 2 Mas an autoperformed? On (Street an Town, Stete the cause(s) me, date and 29d. Det	bus contril usa contril who sell psy 2 Other (in y occurred of Number of sell) end manned place, end the signed (in the s	bute to the Probate 24b. Were availage composed of decreases a state of due to the Month, Da	pproximate terval Between nset end Death nset end D



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death ini Fe6 10.35 Am 1999 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltanose

| Baltanose
| Bunder 1 Yeer | If Under 24 Hrs. | 8, Dete Baltemore. trankin woods Center. 7. Age (In yrs, last birthdey).

Yrs. 6. Sex Birthplece (State or Foreign Country) Deys Hours 1□M 20 F 212-10-3298 10/1 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No lamore 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. ortha 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 X No if Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Ashauer (Surname Unknown) Cennlia 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4315 Silver Spring Rd., Baltimore, MD 21128 (friend) Gloria Freeland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Buriei 2 Cremetion 3 R 3 Removel from Stete Baltimore, Maryland 2/6/99 Moreland Memorial Park 22. Name and Address of Facility Schimunek Funeral Home, Inc. ne of Funerei Servi e Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete triterval Between Onset and Death duor Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 ™ Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Modical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic avent, the Medical Exemplan

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital

the Maryland

death

5. Social Security Number

10e. Street end Number

10th Grade

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in deeth)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last

William F.

10e Stete

Director

Funeral

p

Completed

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Physician/Medical by Completed Be Certification:

physician and the buriel-transit signed by the at d be detached fo peen certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

Medical

State Registrar

25. Was case referred to medical 1 Yes 2 No 27. Manner of Deeth 5 Pending investigation 1 Neturel 2 ☐ Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 😢 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceuse(s) and manner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

29d. Dete signed (Month, Day, Year)

Dièce Boltimore MS 21237.

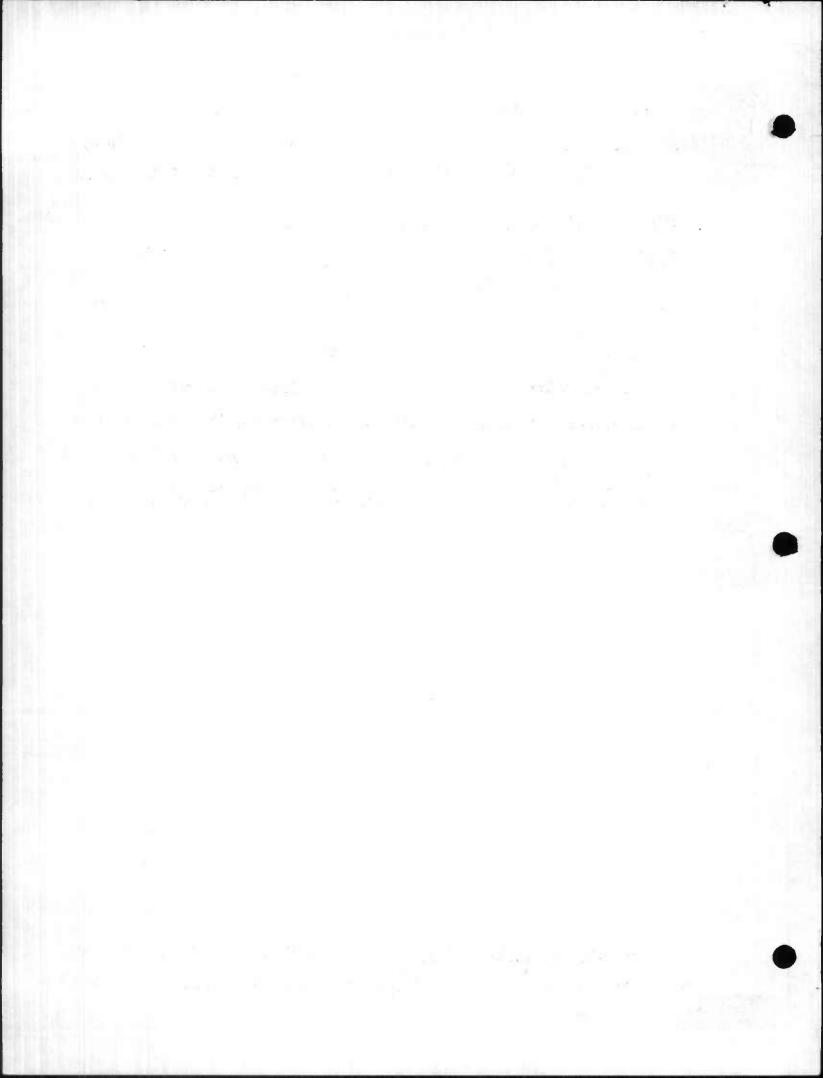
30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

AN Ralaxah 9105 Franklin Square

31. Dete filed (Month, Dey, Year) FEB 0 4 1999

29b. Signeture and title at certifier

32. Registrer's Signature



Registrar

31. Data filed (Month, Day, Year)

29b. Signetura end titla of certifiar

FEB 0 4 1999

Anni and

30. Nama and address of person who completed causa of daath (Item 23e) (Type, Print)

32. Registrer's Signatura

RAVIMO, NHC, BALTO. MD. 21133

29c. Licansa number

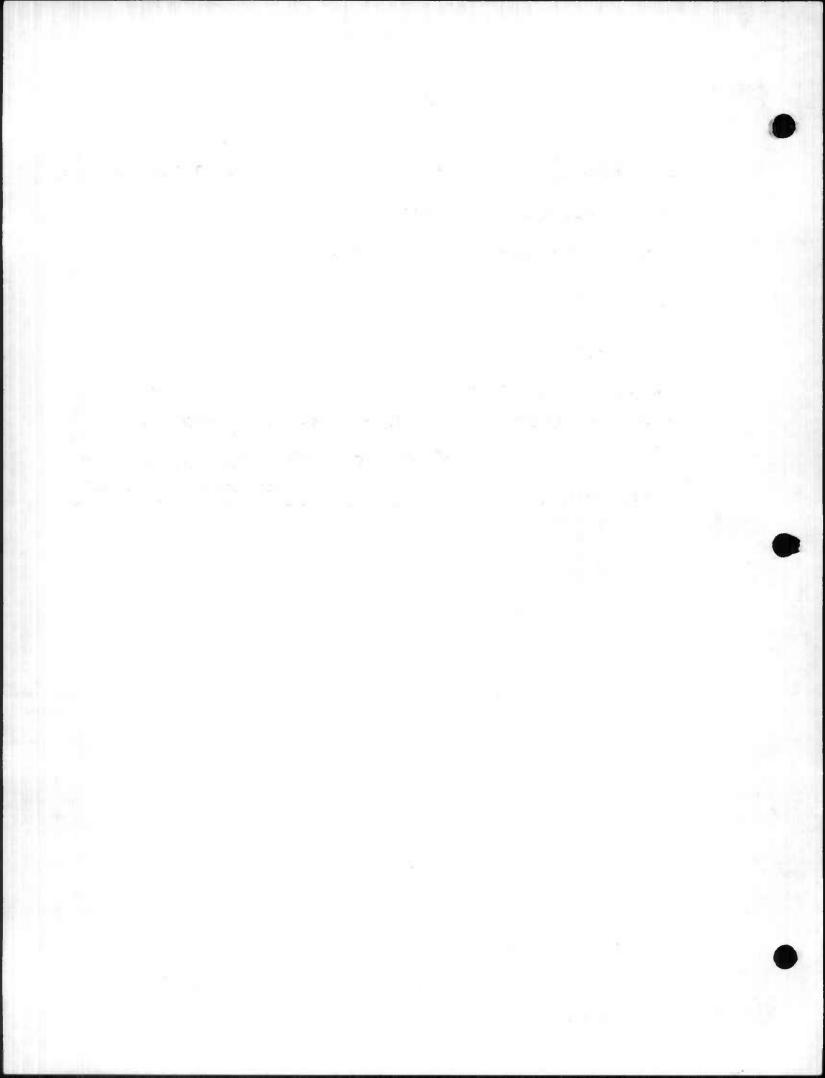
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29d. Data signed (Month, Day, Year)

FEBRUARY 2, 1999

To the within 2

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ONAL. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth If Under 24 Hrs. Birthplece (State or Foreign Country) Days Hours 212-38-1481 07-02-1939 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 14. Rece - American Indien, Bieck, White, etc. 611 S. Charles Street 21201 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Social Security College (1-4or 5+) 12 Years Administration 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Earl Smith Helen L. (Unknown) 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Doug Twigg(attorney) 1132 River Bay Road Annapolis, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Services Corp. 2-2-99 Towson, Maryland 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility Leonard J.Ruck, Inc. J. Wayne Osterling | 5305 Harford Road Baltimore, Maryland 21214 use, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) Stoff, wwens bothismis Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In death) Last G Take Sele Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 No 1 Yes 1 🗆 Yes 2 No 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The lew requires that the death certificate be been signed by the should be detech certificate this After death, To the Hospital or Attendition within 24 hours efter death.

To the Funeral Director: A completely filled in by the fi

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6 items 23s Director

Funeral

by

Completed

Be

traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after death nend Mental Hygiene. Is marked other than "natural", or items 23.

permit. Pages 1 end 2 Department of Health e Important: If Itam 27 is eny Injury or other tra

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

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Medicai Certification: To

Baltimore, Maryland 21215-0020

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Maturel 1 TYes 2 TNo investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier

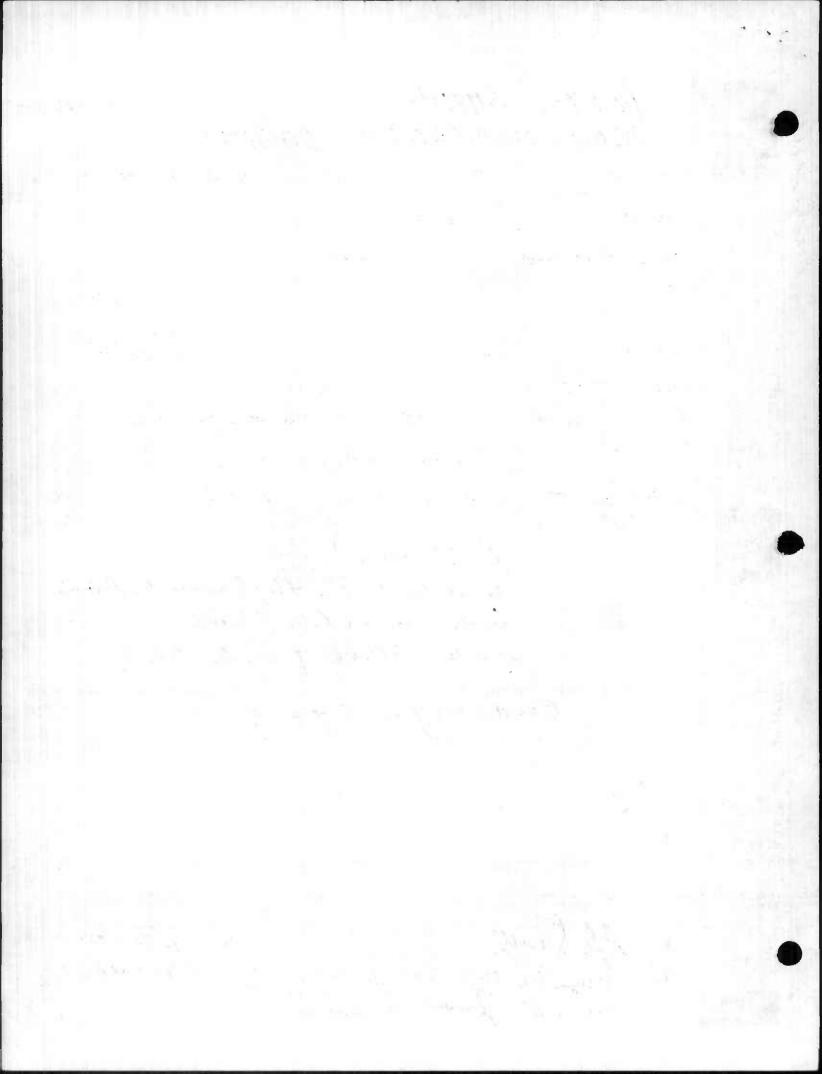
29b. Signeture and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

of death (Item 23a) (Type, Print) DOLPIHIN ST. BALT. HD 28267 31. Date filed (Month, Dey, Year,

State Registrar 32. Registrar's Signature



Examiner attending physicien and for use as the bunal-trans Box 68760, Division of Vital Records, has or Attending Physician: ofter death. Director: Atter this certific director,

Examiner Physician/Medical Completed Be o L luneral Certification:

Physician

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item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 sh Department of Health end Important: If item 27 Is m any Injury or other traum once.

Physician

/Medicai

1 2 should be filed within 72 hours efter death vinend Mental Hygiena. Is marked other than "natural", or hame on-

Saitimore, Maryland 21215-0020

with the Maryland

	Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	
27.	Manner of Death	

26a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

2 Accident

3 Sulcide

4 Homicide

Certifying Phyeician: To the best of my knowledge, death occurred at tha tima, date and piace, and due to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and the ot certifier Dar

D 40390

29c. License number

FEBRULLY 3 1999

29d. Date signed (Month, Dey, Year)

30. Nama and address of person who complated ceusa of death (Itam 23a) (Type, Print)

P. LIDESH MA. 536 OLD COURT LO. # 201, PAND ALGORIUM, MD 21137 31. Date liled (Month, Day, Year) 32. Registrar's Signature

Registrar

Medicai

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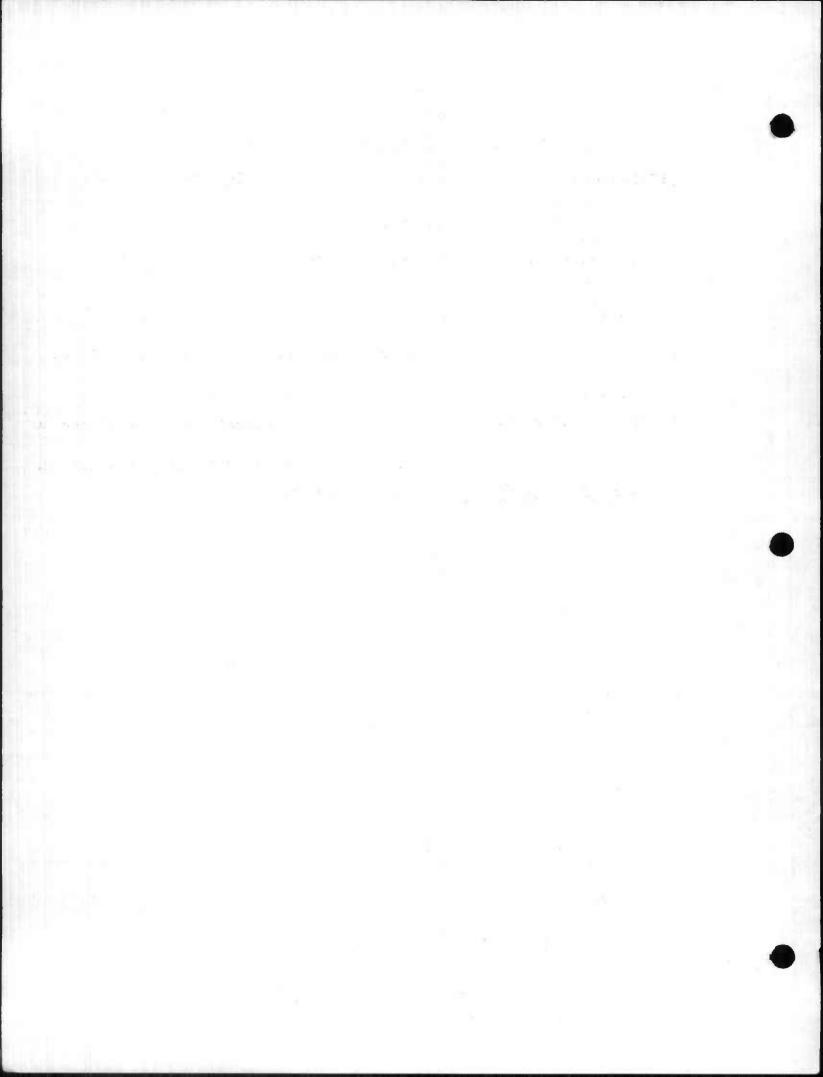
6 Could not be determined



To the Hospital within 24 hours To the Funeral

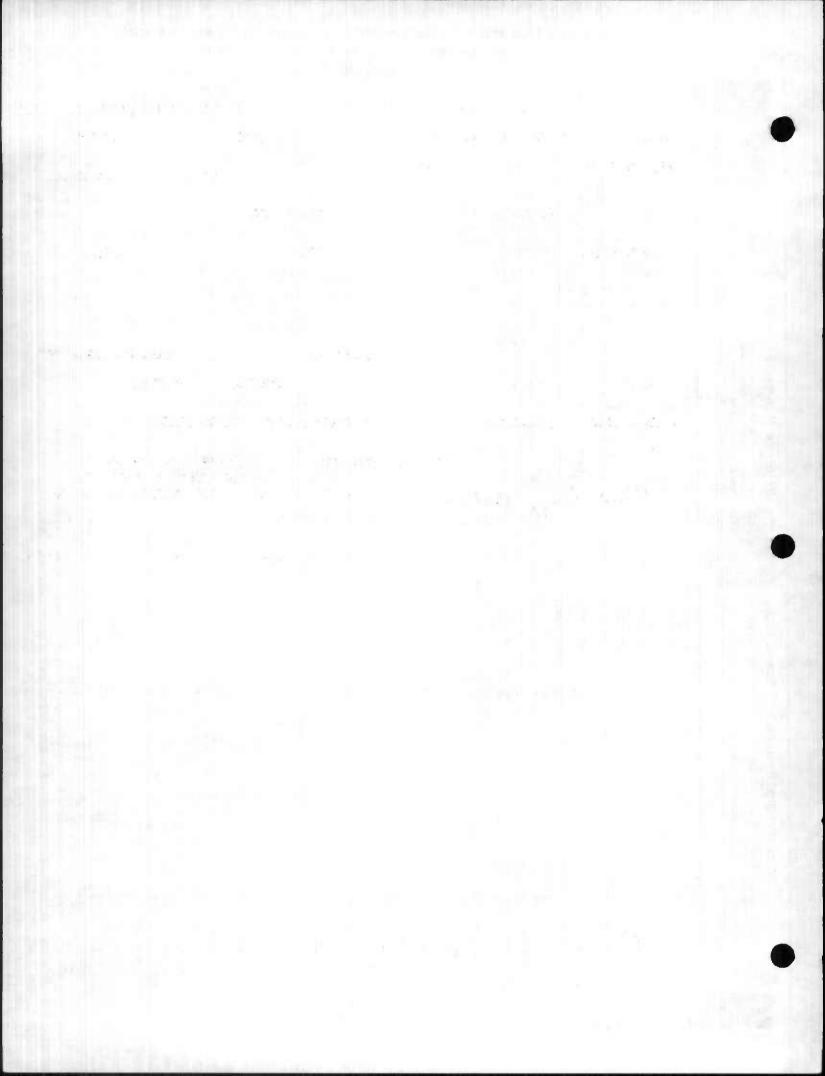
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Physicia	an	Decedent's Neme (First, Middle, Last	st)					2. Date of D Month	eath Day	Year	3. Time of Death
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Examin Funeral Director	er	217-34-8469	Healt 7. Age	LCO o (In yrs. lass 63		Under 1 Year onths Deys	B AZ	in. (Month, L	5		ce (Stete or Foreign
pue A		Usual Residence of Decedent 10e. State 10b. County		10c City T	own or Location	on				104	. Inside City Limits
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28a	Director	MD NA 10e. Street and Number		Dal	imore	Of. Zip Code			10g. Citizen of V	What Country	7
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72 hours		****		1	6a. Decedent	's Usuei Occu	pation		16b. Kind of Bu		
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il Hygi	Be C	17. Father'a Neme (First, Middle, Last)			02.001	. u u u p		leme (First, Middl	e, Meiden Sumer		3400
should be and Mentel or marked or umatic eve	To B	Robert Ware					Edith	Tucker			
ice, Maryland 2 s 1 end 2 should be filed f Heelth end Mentei Hygi tem 27 is marked other other traumatic event, I		19a. Informant's Name/Relationship (7			19b. Mailing A	ddress (Stree	and Number or	Rural Route Num	ber, City or Town,	State, Zip Co	ode) 21216
		Lynard N. Tuck	er-Son				rton H		Ave, Ba		ore Md
		20a. Method of Disposition √ Buriai 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specify	Removal from State	20b. Plec	e of Disposition of the	n (Neme of ary or other ple	ica)	Dete	20c. Location -	City or Town	, State
Saltimo bemit. Page Department of mportant: If any Injury or ance.				Garı				2/8/99	Owings	s Mill	ls, Md
Baltill pemit. P Departme Importan sny Injur pace.		21. Signeture of Funerel Service Licum	200	1		ch F/	H West				
	Н	23a. Part1. Enter the disease, or comp shock, or heert failure. List only	Mari		430	0 Wab	ash Av	e, Balt	imore N	1d 2	1215 pproximete
BOX 68 /60, seth certificate be assected ettending physician and for use as the boost-transit	n/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	NTP Due to (or es	a consequent of	ce of):	nt ve				
box.	icia	Part ii. Other significant conditions co	entributing to death bu	t not resultin	in the under	tvino causa di	ven in Part I	23h Die	f tobacco use co	ntribute to th	ne cause of death?
	by Physician/M		with bothing to doubt but		g in the driver	lying cause gr	voir ni r dit i.		Yes 200 No	3 Probeb	
Physicien: The law requires this certificate has been signed in director, page 2 should be a	Completed b							24e. Wa	s an autopsy formed?	evalia	autopsy findings able prior to eletion of cause ath?
The The page	Con							1	Yes 2 No	1 🗆 Y	'es 2 1 No
yaicien: The law yaicien: The law is certificate has b director, paga 2 s	Be	25. Was case referred to medicel examiner?	Hearital 2			I o		eath (Check only	one)		
Attending Physicien: or death. ector: After this certific by the funeral director.	ation: To	27. Menner of Death 1 Netural 5 Pending investigation	1 Inpatier 28a. Date of Injur (Month, Day	y 28	b. Time of Injury	28c. Inju			sidence 8 D0th how injury occurr		
To the Hospital or Attending Phywithn 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:	3 Sulcide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home (Specify)	, farm, street,	fectory, office		28f. Location City or To	(Street and Numb own, Stete)	er or Rural R	oute Number,
Ne Hospital or no 24 hours after to Funeral Dir pletely filled in	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	reician: To the best of iner: On the basis of end manner sta	examinetion	dge, death occ end/or investi	curred at the ti gation, in my	me, dete end ple opinion, deeth oc	ce, end due to the courred et the time	e cause(s) and ma e, dete end pleca,	anner as state and due to the	e ceuse(s)
To the within 2 To the comple	Σ	29b. Signature end title of comilian	2.1/1)		29c. Licens	se number		29d. Dete signe	d (Month, De)	y, Year)
1/1		1	VE	/			644211		2/2/	99	
101		30. Name and address of person who	1	ath (Item 23		1.		1			
Stat Registra		31. Dete filed (Month, Dey, Year) FEB 4	32. Registra	s Signature		Spi	nels		ne-Asp		H



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			Certi	ficate of	Death		Reg. No.	02300					
Dhamisian	1. Decedant's Nema (First, Middla, Las		_ ^	22 -		2. Data of Dec		3. Time of Deeth					
Physician /Medical	DOF	RIS M.	THAI			FEB	011	999 11:16 P.N					
Examiner	4a Facility Neme (If not institution, giv. HOWARD COUNTY G		AL.	ľ	tb. City, Town, or COLU	Location of Deeth	4c. County o	HOWARD					
Funeral Director	5. Sociel Security Number 6. S 213–20–3770 1	ex 7. Age (In yrs		If Under 1 Year Months Days	If Undar 24 Hrs Hours Min			Birthplece (State or Foreign Country) MARYT.AND					
2 .	Usual Residence of Decedent	140- 0	ity. Town or Local	l'an		2/11/	1341						
e Marylu la-f show dfied at ctor	MD 10b. County BALC	rimore 106. C	ity, town or Local		ONSVILL	Е		10d. Inside City Limits 1 ☐ Yes 2 💢 No					
ar death with the Maryla Herns 23s or 25a-t sho ner must be notified at uneral Director	10e. Street and Number 409 H WHEATON P	LACE		10f. Zip Code 21.2	228		10g. Citizen of W	thet Country?					
020 un mil Exami	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedant Evar In U Armed Forces? 1 Yes 27 No If Yes, Give Yeer or Detes:		s Decedant of Hes, specify Cube	lispenic Origin? (S en, Mexicen, Puer Specify:	Specify Yes or No to Ricen, etc.)	14. Race Bleck Specify:	- Americen Indian, , White, etc. WHITE					
1 21215-0 ad within 72 ho wer than "naturn it, the Medical.	15. Decedent's Ed (Specify only highast gre	lucation de completed)	(Give kin	nt's Usuel Occup	during most of wo	orking	16b. Kind of Bus	iness/Industry					
121 remin Parks alks	Eiementery/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired	3)								
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land land kad off cever o Be		RHOLD			SOP		(ZIMMERMAN)						
Maryland d 2 should be fin f) and Mental Hy 7 is marked othe traumatic event	19e. Informent's Neme/Reletionship (Type, Print)	19b. Malling	Address (Street	end Number or A	urel Route Numbe	er, City or Town, S	State, Zip Code)					
Mg 27 is 27 is 1		HUSBAND)	409 H	WHEATO	N PLACE	CATONS	VILLE, M	D 21228					
other other	20a. Method of Disposition		Plece of Dispositi	ion (Neme of	ce)	Dete	20c. Location - 0	City or Town, State					
Page ment of		Hemovel from State				2/5/99	WOODI	AWN. MD					
Baltimore, permit. Pages 1 is Department of Heis Important: If item any injury or othe ance.	206. Method of Disposition 1 Sturial 2 Cremetion 3 Removel from State 4 Donetton 5 Other (Specify) 21. Signature of Funerel Service Licensee Public 1 Signature of Funerel Service Licensee 1630 EDMONDSON AVE CATONSVILLE, MD 21228												
	23a. Pert1. Enter the disease, or complete ions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.												
Physician /Medical Examiner	Immediate Ceuse (Final disaesa or condition resulting in deeth)	. CEREBI		CULA				Onset and Deeth 5 DAYS					
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death death e attended for u	Pert II. Other significant conditions of	ontributing to deeth but not re	sulting in the unde	erlying ceuse gh	ven in Pert I.	23b. Dld	tobacco use con	tribute to the cause of death?					
P.O. hat the deteched by the d						10	Yss 2□ No	3□ Probably 4河 Unknow					
aw requires been 2 should							en eutopsy irmed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?					
	Salaman Colonia					1 🗆	Yes 2 KNo	1 ☐ Yes 2 ☐ No					
Vital Files of certificate irector, pag	25. Wes case referred to medical exeminer?					eeth (Check only	one)						
0 5 53	1 ☐ Yes 25XNo		ER/Outpetient	3LI DON		Home 5 Resi							
C a ser co	27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Inju Wo M 1□	ry et rk? Yes 2 □ No	28d. Describe	how Injury occurr	ed					
Division of the or attending P is a field death. al Director: After the field in by the funera Certification:	3 Suicide 6 Could not b	28e. Plece of Injury - At I building, etc. (Spec	home, farm, stree ify)	t, factory, office		28f. Location (City or To	Street end Numbe wn, Stete)	er or Rurel Route Number,					
Divisio To the Hospital or Attendit within 24 hours after death, To the Funeral Director: A completely filled in by the fr		yelclan: To the best of my kn niner: On the basis of exemin end menner stated.											
To the comp	29b. Signatura and titla of certifiar	10		29c. Licans				(Month, Dey, Year)					
/	Hueda	Ali Kho	an M.D	-	+332		FEB,						
5	30. Neme and address of person who	completed cause of death (ite	m 23e) (Type, Pr _ N E Y	int) 181 MD	11 PR	INCE 1	4111	DRIVE,					
State Registrar	31. Dete filed (Manth, Dey, Year)	32 Pregistrar's Sign	neture 4	Thomas	1								

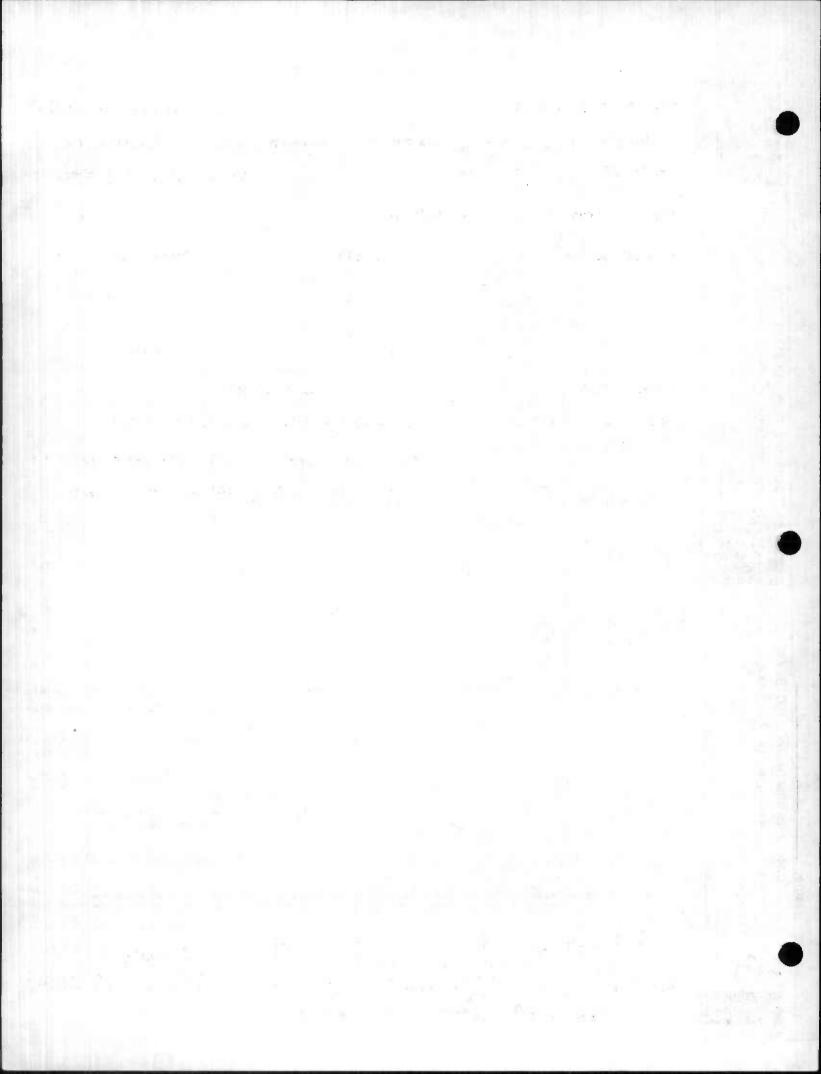


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State of Maryland / Department of Health and Mental Hygiene 99 029

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	Physic	ian	1. Decedent's Neme (First, Middle, Las	•					2. Dete of D Month	Dey	Yeer	3. Time of Deeth
	/Medi			anner				n or 7	Janua		199	1:35117
	Exami	ner	4e. Fecility Neme (If not institution, give	win Car	e Ce	ente	~	4b. City, Town, or Cato N	SVI Le	th 4c. County		none
	Funeral Director		5. Social Security Number 6. St 016-07-1125	D	o (In yrs. las 84	Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs Hours Min			9. Birthple Count Mass	ece (State or Foreign ry) achusetts
	p ,		Usual Residence of Decedent 10e. Stete 10b. County		10-01-1						-	
	the Marylar 28a-f show	ctor	MASS. Frankl:	ln		nfield					10	od. Inside City Limits 1 X Yes 2 □ No
	ith th	Oire	10e. Street end Number				10f. Zip Code			10g. Citizen of	What Count	ry?
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21215-0020	within 72 hours ene. than "natural",	Completed	15. Decadent's Ed (Specify only highest grade) Elementery/Secondary (0-12)	ucation de completed) College (1-4or 5-		(Give ki life. D		petion during most of world)	orking	16b. Kind of Business/Industry		
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			23a. Pert1. Enter the disease, or comp shock, or heert feilure. Liet only of	licetions thet caused	the deeth.	An	napolis	, MD 214	01			
2	Physician /Medicai Examiner		shock, or heeft feilure. Liet only of immediate Ceuse (Final disease or condition resulting in deeth)	e. Sh	rok	e						Approximete Interval Between Onset and Deeth
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> 1	00	ToB	examiner?	Hospitel: 1 ☐ Inpatien	t 2 ER	VOutpetient	3 DOA ON	ner L		Idenca 6 □Oth	ner (Specify)	
	ter th		27. Manner of Deeth 1 ☑ Naturel 5 ☐ Pending	28a. Dete of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. Inju Wo	ry et	28d. Describe	how Injury occur	red	
O S	Attending r death. ector: After by the fune	catic	2 ☐ Accident investigation			,,		Yes 2□No				
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1	within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	sician: To the best of lnar: On the basis of e	exeminetion	dge, deeth o end/or inve	ccurred et the ti stigetion, in my	me, dete end piece opinion, deeth occ	e, end due to the urred et the time,	cause(s) and me date end plece,	enner es ste end due to	ted. lhe cause(s)
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	5		30. Name and address of parson who c	ompleted cause of dea	Marc	1 (hoice	Lax	B	Human	O M) 1949 D 21228
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 900pm **Physician** MICHAEL F. TROSTEL /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner Baltimore City Hospital maryland General 8. Date of Birth (Month, Day, Year) MAY 19, 1931 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2□ F 212-30-9577 67 Yrs. MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 □ No rector MD BALTIMORE 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 늅 7 is marked other than "natural", or items 23e or itemstic event, the Medical Examiner must be n 1307 BOLTON ST. 21217 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa, DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) PRESERVATION College (1-4or 5+) Elementary/Secondary (0-12) ARCHITECT ARCHITECT is marked other 18. Mother's Name (First, Middle, Maidan Sumema) 17. Father's Name (First, Middla, Last) Pages 1 and 2 should be and Mental LOUIS J. TROSTEL KATHARINE FISHER 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) LOUIS J. TROSTEL JR. (BROTH.) BOX 199 PRINCETON, MA. 01541. Department of Health mportant: If Item 27 20b. Place of Disposition (Nama of cemetery, cramatory or other place) Dafe 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 8 GREEN MOUNT CREMATORY02/04/99 BALTO., MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses HENRY W. JENKINS & SONS O 4905 YORK RD. BALTO., MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsef and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last attending physician and Box 68760. The law requires that the death certificate be Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. P.O. the signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 2 Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed been certificate has 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpafient 2 ☐ ER/Outpatient 3 ☐ DOA P O within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending 1 DNaturel 5 Pending 1 Yes 2 No Investigation 2 Accident tha 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital edical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifit 29c. License number

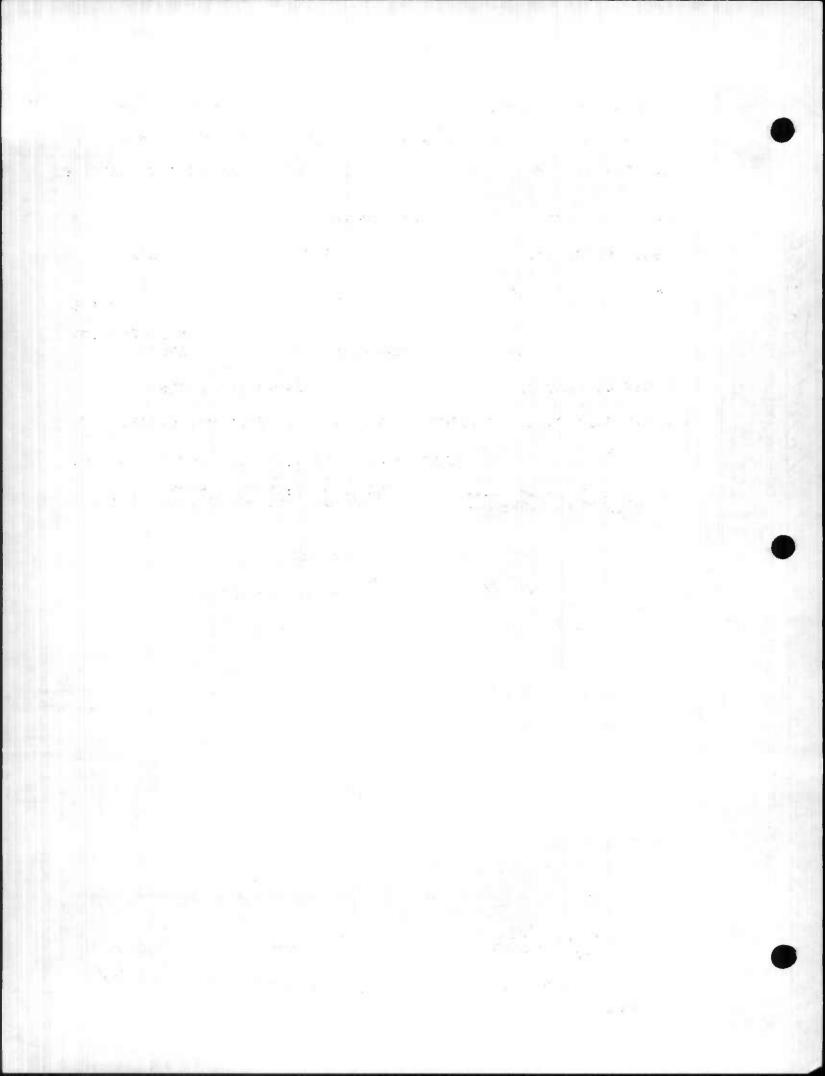
Registrar

Day, Year) 4 1999

40 32 Registrar's Signature

erson who completed cause of deeth (Item 23e) (Type, Print)

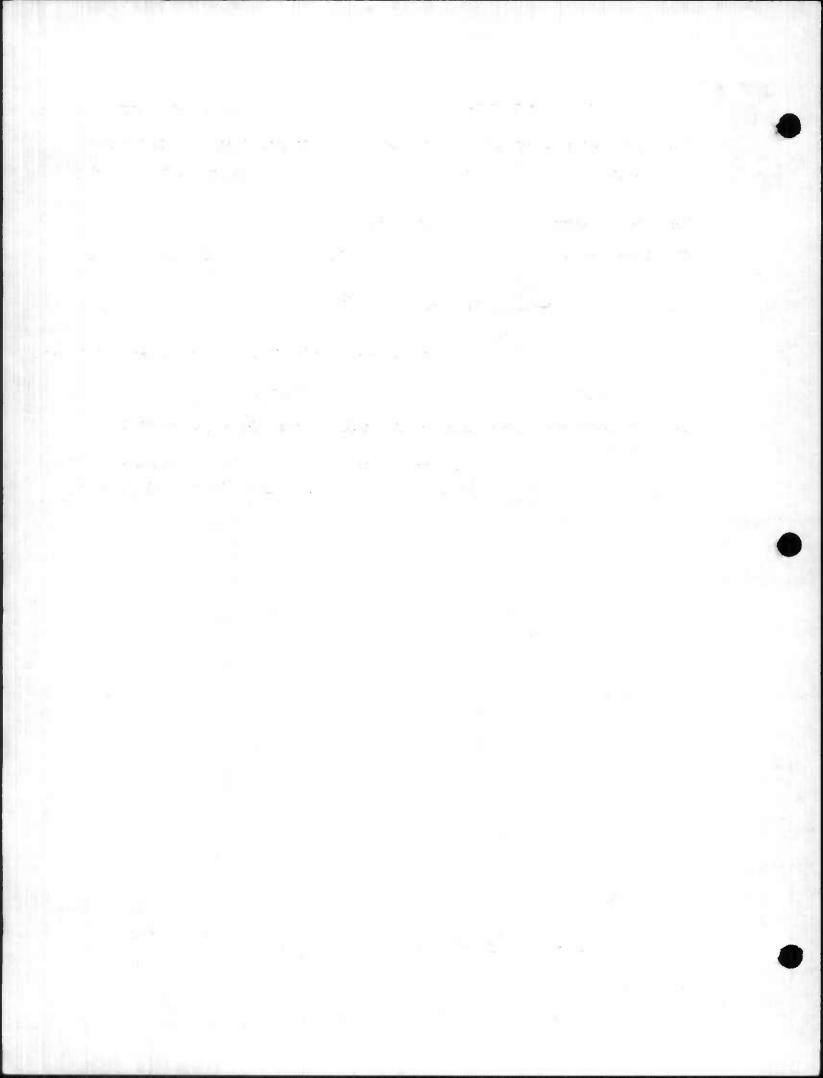
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State of Maryland / Department of Health and Mental Hygiene

							Certificat		Death		leg. No.		
ı	Physici		Decedent's Name (First, Mic Bett	_{ldle, Last)} y–Rogers	Wanat	t				2. Dete of Dea Month January	Dey	Yeer 999	3. Time of Death 8:50am
	/Medi Examir		4e. Fecility Nama (If not institut	ion, giva street an	nd number)				4b. City, Town, or I		4c. County		O. Journ
			Holy Cross Reh	ab & Nur	sing (Care Cen	ter		Burtons	ville	Mon	tgomer	y
	Funeral Director		5. Sociel Security Number 482–18–2514	6. Sex 1 □ M 2 💆		(In yrs. last birth 77 Yı	day) If Under Months	1 Yaer Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March			e (State of Foreign
	how		Usuel Residence of Decedent 10e. Stete 10b. Cour	ty		10c. City, Town	or Location					100	1. inside City Limits
	e F	cto	Maryland Ho	ward		Col	umbia						1 ☐ Yes 2 → No
	٩ ا	Oire	10e. Street and Number				10f. Zip				Og. Citizen of	THE PARTY OF	
	ath w	La	6308 Dewey Dri					210				d Stat	
21215-0020	filed within 72 hours effer death with the Meryland Hygiene. ther than "natural", or flema 23a or 23e-f ahow ent, the Medical Examine must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 M 32 Widowed 4 Divorce	orried table	Decedent End Forces? Yes 2 No. No. No. No. No. No. No. No. No. No.	ver in U,S. 948-50	13. Was Deced		dispenic Orlgin? (S an, Mexican, Puert Specify:	pecify Yas or No- o Rican, etc.)		e - Amarican ck, White, etc	c.
Ō.	n 72 hours "natural", edical Exp	pe	15. Deced	ent's Education	6 3 a	16a. C	ecedent's Usua	i Occup	pation		16b. Kind of B	usiness/Indu	stry
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nd	should be filed within and Mental Hygiene. marked other than imatic event, the Market than imatic event, the Market the M	Be (17. Fathar's Name (First, Middl	e, Last)					18. Mother's Nen	ne (First, Middle,	Meiden Suman	ne)	
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	1 end 2 Health em 27 l		Ross & Karen R	appaport	/Execu				1 Avenue				
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	Pa Partition		4 Donation 5 Other	(Specify)		Metro	Cremato	ry		2-3-99	Caton	sville	, MD
Baltimore,	permit. Pages 1 end Department of Health Important: If item 27 any injury or other tr 2005.		21. Signeture of Funerei Service Licensee Them Co. Columbia - Witzke's Family Funeral Hom 4112 Old Columbia Pike Ellicott City										
	Physician /Medical		23e. Pert1. Enter the disease, shock, or heert feilure. Li	or compileations t st only one cause	het caused t on each line	he death. Do no						A	opproximete interval Between Onset and Death
	Examiner	immediate Cause (Final disaasa or condition resulting in death) a. Stocks											montho
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	To the Hospital or Attending P within 24 hours effer deeth. To the Funeral Director: After t completely filled in by the funera	edical	29e. Certifier (Check only one) (Check only one)	it Examiner: On t	the best of he basis of e mannar stete	exeminetion end/	deeth occurred or investigation,	in my o	me, dete end plece opinion, deeth occu	, end due to the c rred et the time, c	ause(s) end mi lete end plece,	anner as stet and due to th	ed. ne cause(s)
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	1		Paul Armstr	ma. M	0 1	1201 La	zurel P	cuk	Dr. Ste	102 La	usel m	p 20	767
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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#7 per FH G768 2/4/99 EW 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) **Physician** 2210 February 2 1999 Williams /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore Sinai Hospital of Raltmore If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1 DXM 2 □ F 59 56 **Director** 214-40-1777 27 M.D. 01 Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits over its marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at 1 Yas 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 3109 Ferndale Ave Funeral 12. Was Decedent Evar in U,S Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yas 2 ☑ No tf Yes, Give Yaar or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grinder Armco Steel 8th grade 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 12 should be find and Mental His marked off Hazel Fowlkes Andrew Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health Important: If Item 27 21207 3109 Ferndale Ave, Baltimore Md Charlotte Williams-Wife 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Removal from State 2/6/99 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Park Arbutus, Md any Injury 22. Nama and Addrass of Facility March F/H West 21. Signature of Funeral Service Licenses 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Seps13 /Medical Examiner Due to (or as a consequence of) Examiner ecrotizing fascutis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown py Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 ☐ Yes 212 No 1 ☐ Yes 200No certificata 25. Wes cese referred to medicat examiner? 26. Plece of Death (Check only one) Be Hospitat: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 12 npatient 2 ER/Outpatient 3 DOA P 1 ☐ Yes 2 No After this 27. Menner of Death 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 5 Pending Investigation Attending efter death. 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Sulcida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) within 2. To the F To the 296. Signature and title of certif 29c. Licensa numbar 29d. Date signed (Month, Day, Year) 4524623210K9195

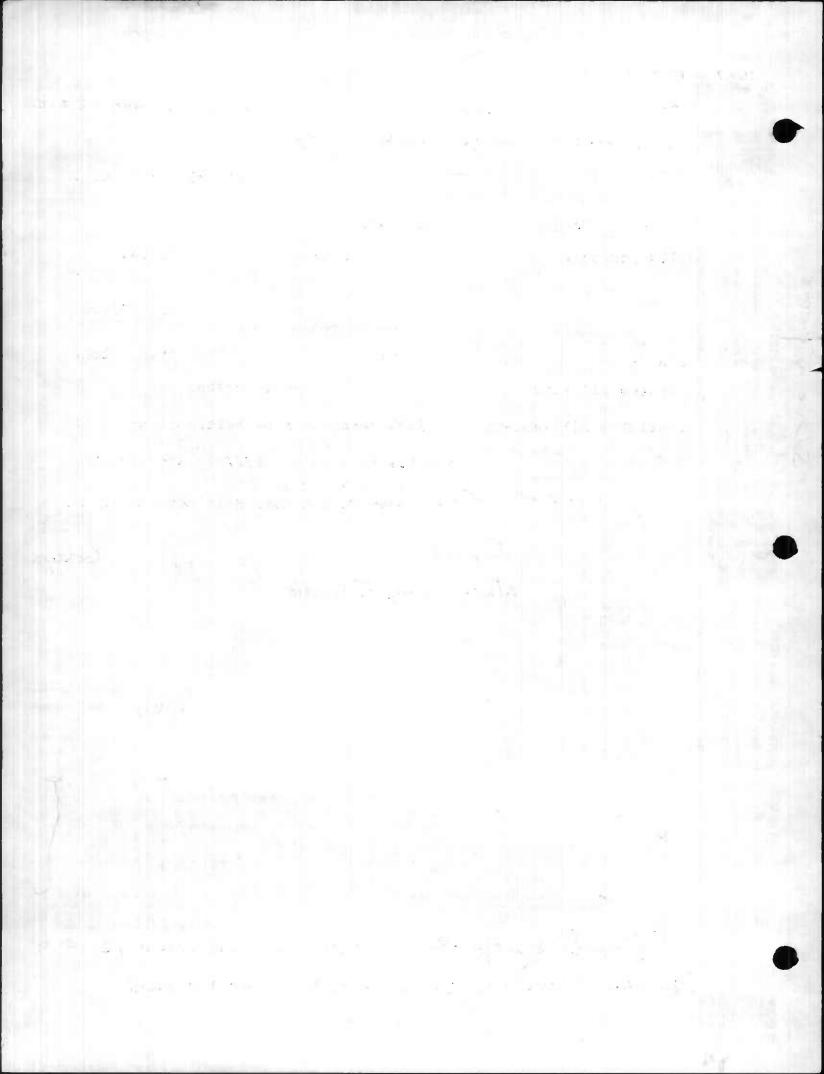
State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) 32. Registrar's Signeture 4 1999 FEB

W. Revedere Ave, Beltimore, HD 21215

deeth (item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death Month Violet Broadwater 0951 JAMUAN 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Elkton Hospital Inion If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yaar) Sept. 22, / 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 1□ M 20 F Hours 77 Yrs. 219-22-0109 Maryland Usual Rasidance of Dacedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Elkton 1 Yas 2 No eci 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Manor 21921 U.S.A. ollingsworth 12. Was Decedant Ever in U,S.
Armed Forcas?

1 ☐ Yas 2 ☑ No
If Yes, Giva
Year or Datas; Was Decedant of Hispanic Origin? (Specity Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indien, Biack, Whita, atc. 11. Marital Status 1 Navar Marriad 2 Married 1 Yas 2 No Spacity: Specify: White 3 Widowed 4 □ Divorced 15. Dacadent's Education 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry (Specify only highast grada completed) Elemantary/Secondary (0-12) College (1-4or 5+) Cateteria manager Board of Education 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Meidan Sumama) Anna Moore William Mae 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) Ronald H. Martin Cecilton Manor Dr., Warwick, MD. 21912 13 20b. Piaca of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Crametion 3 Ramoval from Stata 1/25/99 Elkton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gilpin Manor Memorial Park 21. Signature of Huneral Service-Closes 22. Nama and Addrass of Facility Gee Funeral Home 259 E. Main St, Elkton, Maryland 21921 23e. Part1. Entar tha discrete, a, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximata Intarval Batween Onset end Death Sudden Cardiac Death Immediate Causa (Final minute disease or condition rasulting In death) Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Disaasa or injury that initiated avants resulting in daath) Last ypertension Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? pertension 1)X Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings availabla prior to complation of cause of death? 24a. Was an eutopsy performed? 1 Yas 2 No 25. Wes casa raferrad to medical 26. Placa of Deeth (Check only ona) Othar: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yas 2X No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medicai Examiner ician end buriel-transit

Box 68760.

P.O.

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Physician

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Examiner

Funeral

Director

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Peges 1 and 2 should be filed within 72 honent of Health end Mental Hygiene.
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permit. Pege Department of Important: If any Injury or once.

21215-0020

Baltimore, Maryland

Director

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Completed

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Examiner

physician s the buriel Physician/Medical signed b by Completed pege 2 To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director; to Certification: To

certificate

27. Mannar of Daath

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2 Accidant 3 Suicida 4 - Homicide 29a Cartifian

1 Natural

5 Pending investigation 6 Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of

28a. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 TYas 2 No

28d. Dascribe how Injury occurred

28f. Location (Streat and Number or Rurel Routa Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the causa(s) and menner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signatura and titla of certifian ous, MD

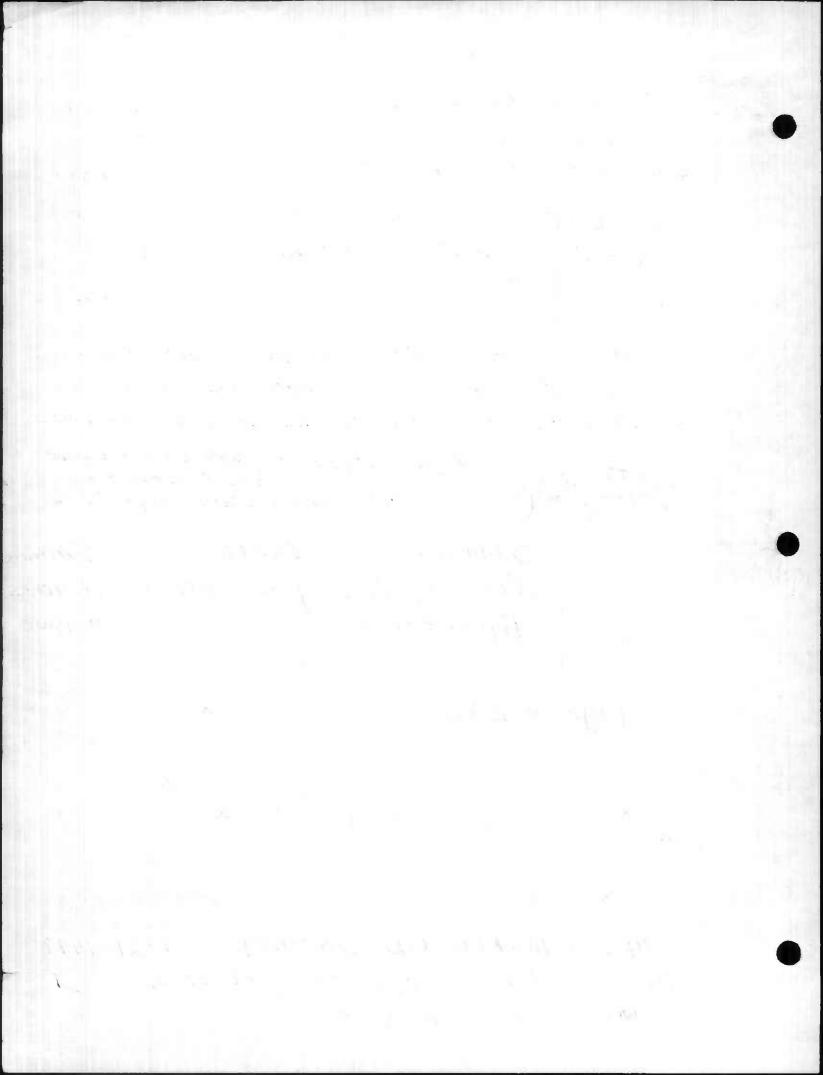
29c. License numbar

29d. Data signed (Month, Day, Year)

street, ELKTON, MD 21921 31. Data filad (Month, Dey, Year)

State Registrar

JAN 2 5 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death #4a. Per Phys. PGC 1-19-99 cr 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** MARY E. **JANUARY** 11,1999 15:00 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. COUNTY HOSP Gladys Noon Spellman Nursing Home CHEVERLY PRINCE GEORGES 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Months Devs Hours Min. (Month, Dey, Year) 5 Social Security Number Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 F 70 223-32-8992 Director JUNE 18,1928 VIRGINIA Usual Residence of Decedent the Maryland r 28a-f show 10a Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director PRINCE GEORGES OXON HILL 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or items 23s or 20745 903 IRVINGTON ST. UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Race - American Indian, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus pemit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Madical Evanties page. Black, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK À 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) CLERICAL PRIVATE 18 Mother's Name (First Middle Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be THORNTON BROWN MAGGIE SCOTT 19a. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 903 IRVINGTON ST OXON HILL, MD 20745 ARTHUR L. BROWN /son 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 1/16/99 Suitland, Md. Lincoln Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility POPE FUNERAL HOME 5538 MARLBORO PIKE FORESTVILLE, MD 20747 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** SEPSIS /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Examin -bran Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting In deeth) Last Due to (or es e consequence of): physician a s the burial-Division of Vital Records, P.O. Box 68760, 8 Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contributs to the causs of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. incers 1 Yes 2 No 3 Probably 4 Unknown ħ signed to d be det p 24b. Were autopsy findings evailable prior to Completed 24e. Wes en eutopsy performed? completion of ceuse of deeth? certificate has t irector, page 2 s 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 88 26. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA # 28e. Dete of Injury (Month, Day Yeer) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Attending 5 Pending investigation Naturel 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) or A 4 Homicide hours a Csrtifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) * Within 2 29d. Date signed (Month, Dey, Year) 29b. Signeture end-title of certifier 29c. License number . Marthy MBBS M 16273 D

State Registrar

31. Dete filed (Month, Dey, Year)

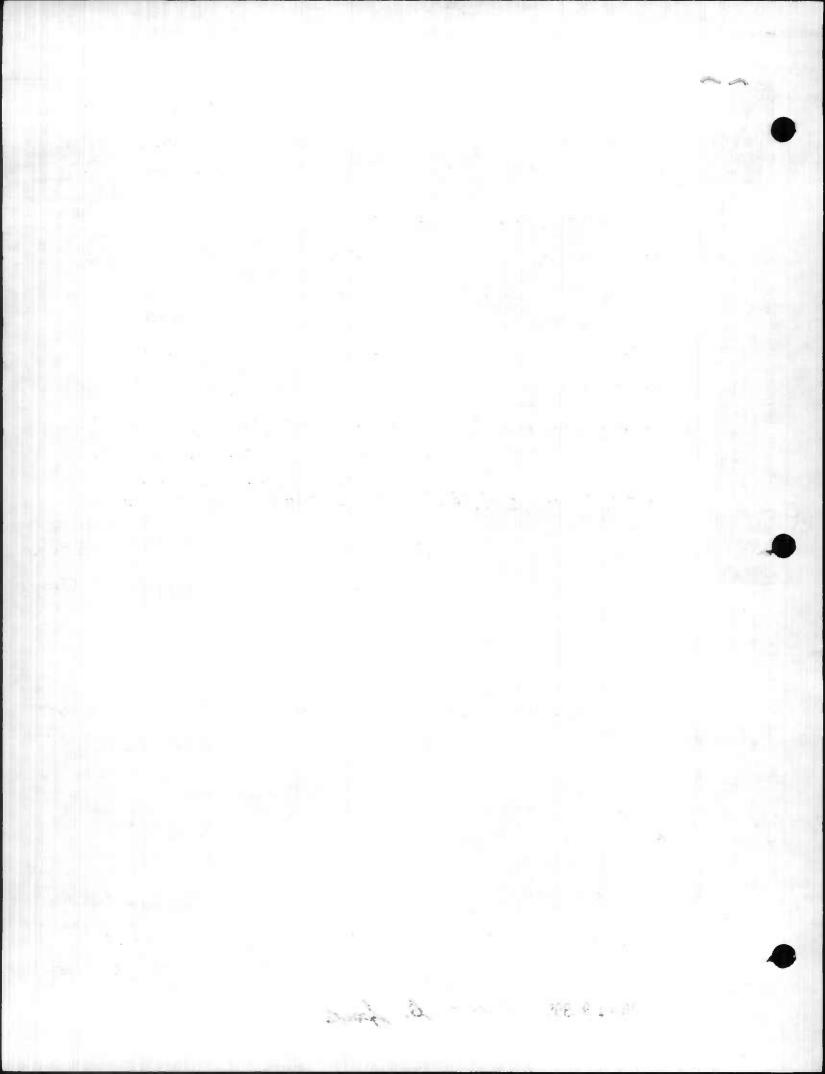
JAN 1 9 1999 **DHMH 16 Rev 6/95**

EVATHU

GI30 CANDOVER RD LANDOVER MURTHY (37 Registrer's Signeture

X40

30 Name and address of person who completed cause of death (Item 23e) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** January 10, 1999 WILLIE ARLETHA BROOKS 2:10 pm /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociei Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1 M 2 XF Yrs. 62 Director April 28, 1936 North Carolina **57**8-52-4667 Usuei Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 12 Yes 2 □ No Directo Maryland Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code r than "natural", or items 23s or the Medical Examinar must be 1 1422 Madison Street 20782 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 25 No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bieck, White, etc. 11. Maritel Status 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 ₩Widowed 4 Divorced **Black** Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs. Government Administrative Assistant pormit. Pages 1 and 2 should be file.
Department of Health and Mertal Hyg.
Important: If New 27 is marked other any Injury or other trausers. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Clarence Marvin Shuford Frances Robinson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8013 East Nalley Road, Landover, Maryland 20785 ce of Disposition (Neme of Dete 20c. Location - City or Town, Stete Wanda Brooks Phillps/Daughter 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 01/19 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Quantico National Ceme. Quantico, Virginia 1999 21. Signeture of Funerei Service Licensee 22. Name end Address of Fecility J.B. JENKINS FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximate Approximate Intervel Between Onset and Deeth Netastatic Lung Carcinoma Unknown
co of):
Failure Physician /Medical Immediete Cause (Finel diseese or condition resulting in death) Examine peratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of) # 985 à 23b. Dfd tobacco use contribute to the cause of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. d by 1 Yee 2 No 3 Probably 4 Onknown benga to det þ 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? page 2 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) TETYOR ZONO 1 Inpatient 10 2 ER/Outpetient 3 DOA 1 28a. Date of Injury (Month, Dey Year) 27. Menney of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 DNaturai 5 Pending I or Attendin after death. Director: Att 1 Yes 2 No Investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 I Homicide 29a. Certifier 11 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. edical (Check only one) 2 Medical Examiner: On the besis of exemination end/or Investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner stated. To the 29b. Signature and title of pertifie 29c. License number 29d. Date signed (Month, Dev. Year) 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Corporate Blod. James Xbaum MH 35. Date filed (Month, Day, Year) 2. Registrer's Signature State JAN 1 9 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O O

hysicia	20	1. Decedent's Neme (First, Middle, L	ast)		7/10				2. Dete of Deet	eg. No. th Dey	Voor	Time of Death		
/Medic	al	IRIS J. BANKS							January	116 1	179 8	:17 ar		
xamin	er	4e. Fecility Neme (If not institution, g. Doctors Comm	nunity	Hosp	ital		4	Lanhar	Location of Deeth		of Death Georg	es		
neral ector		578-66-3177	Sex 7	Age (In yrs 49	. lest birthday) Yrs.	If Under Months	1 Yeer Deys	If Under 24 Hrs Hours Min.	8. Dete of Birth (Month, Dey MAY 9,	Year) 1949 W	9. Birthplece Country) IASHING	(State or Foreig TON DC		
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rictfied	tor	MARYLAND PRINCE	GEORGES	LAN	THAM SEA	A-BRO	OK					Yes 2 No		
0 7 80 101 90	Director	10e. Street end Number				10f. Zip	Code		1	0g. Citizen of W	/het Country?			
		9803 LOCUST AVE.					706			J.S.A.				
0 1	by Fur	11. Meritei Stetus 1 Never Married Married 3 Widowed 4 Divorcad	12. Wes Deced Armed Forc 1 Yes 2 If Yes, Give Yeer or Dete	es? X No	If	Yes, spec		ispenic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	Blec	e - American In k, White, etc. BLACK			
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metic s	ToE	WARREN A. COOK,	SR.				-	BETT	IE B. COI	LE				
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other	+	20e. Method of Disposition		20b.	Plece of Dispos	ition (Nem	ne of							
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Important: If item 27 is any injury or other tra sncs.		Harmony Memorial Park 1-23-99 Landover, Maryland 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility JOHNSON & JENKINS FUNERAL HOM: 716 KENNEDY ST NW WDC 20011												
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		23a. Pen1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Conset and Death												
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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician George Arnold Carlson JAN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON HOSPITAL FORT WASHING TON
If Under 24 Hrs. 8, Dete of Birl PRINCE GEOLGES If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 1∕ M 2□ F Months Days Hours Yrs. Director 218-38-8504 2, 1941 Oct. Washington, D.C. Usual Residence of Decedent tha Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or frame 23a or 28a-f show the Medical Exemples must be notified at Maryland Prince George's 1√ Yes 2 No Director Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15800 Young Ct. 20607 USA death Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, Whita, etc. Tand 2 should be filed within 72 hours effer of Health and Mentel Hyglene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married Maryland 21215-0020 1□ Yes 2√2No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Communications 12th Engineering Associate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Chester Carlson Astrid Norberg 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other the Teresita M. Carlson/Wife same as item 10 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Church Cemetery 1/23/99 Clinton, MD 21. Signature of Funeral Service Licenses George P. Kalas Funeral Home, P.A. ales 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Pak1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical ulmonary Examiner Due to (or as a consequence of) Physician/Medical Examiner O Candia physician and the burlat-transfe tha deeth certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 68760 that initiated events resulting in death) Last Due to (or es a consequence of) U84 88 Box signed by the e P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 2 No 1 Yes 2 No of Vital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division 1 Matural 5 Pending investigation r death. 1 Yes 2 No 24 hours effer death.
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2 Medical Examiner: On this basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hox To the Fune completely fi 29a. Certifier (Check only 29d. Dete signed (Manth, Day, Year) 29c. License number State 19 Registrar

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Day CORLEY ROENNA 11:58 AM 11, 1999 January 4b. City, Town, or Location of Deeth 4e Fecility Nama (If not institution, giva street and number) 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplaca (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yaar) Days Months 1 M 2 F Yrs. South Carolina May 22,1915 244-32-2584 Usual Residence of Decedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits Yas 2 No Washington N/A D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20011 709 Shepherd Street N.W. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2√☐ No If Yes, Give^A Yaar or Detes: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Rece - American Indian. Bleck, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Raymond & Frederick 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Hair Designer Beautician 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Katie Morris John C. Young 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) 709 Shepherd Street N.W. Washington, D.C. 20011 Henry W. Corley - Husband 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1-16-99 Washington, D.C. Glenwood Cemetery 22. Name and Addrass of Facility Marshall's Funeral Home, Inc. 21. Signature of Funaral Sarvica Licansee 4217 9th Street N.W. Washington, DC arsha 23a. Part. Entar the disaasa, or complications the caused the death. Do not entar the mode of dying, such es cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximata Intervel Batween Onset and Deeth Immediata Causa (Final AND ADENOCARCIDIOMA OF LIVER BILE DUCT disease or condition resulting in death) Dua to (or as a consaquanca of): FIBILATION PAROXUSMAL ATRIAL Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or injury that initiated events rasuiting in daeth) Lest Dua to (or as a consequenca of): ARTERITIS GIANT CELL Due to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yee 2 No 3 Probably 4 Unknown DEHYDRATION 24b. Ware autopsy findings aveilabla prior to complation of cause of death? 24a. Was an autopsy PERTENTION 1 ☐ Yes 2 No 1 ☐ Yas 2 No 28. Placa of Death (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Director

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State Registrar 25. Was casa rafarred to medical Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury et Work? 1 Naturel 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Roula Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Certifiar 🖄 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, dete end place, and due to the causa(s) and manner stated.

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29c. Licansa number D. 17656 29d. Data signed (Month, Day, Year)

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1200 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

TIPAPOEN WOODWARD 5530 WISCONSIN AVE 4 550, CHEYN CHASE, MD 20815 M.D

31. Date filed (Month, Day, Year) JAN 1 9 1999

29b. Signatura and titla of cartifiar



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State of Maryland / Department of Health and Mental Hygien 9 029 3

					Certificat	te of	Death		Reg	. No.	06210
		1. Decedant's Nama (First, Middle, La	est)						of Death	D V	3. Time of Death
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V 12	/Medical Examiner	4a Facility Nama (If not institution, give	ve street and number)				4b. City, Tow	n, or Location of		4c. County of De	ath
	LAGIIIIIICI	7702 Hanover Par	kwav #204				Greenb	elt		Prince	George's
	uneral			yrs. last birt		r 1 Yaar	If Under 2	Hrs. 8 Data	of Birth		irthplace (State or Foreign Country)
	rector	301-12-0407	1⊠ M 2□ F 78		Yrs. Months	Days	Hours	Min. (Mon	th, Day, Y	1920 Not	rth Dakota
yland	ě u	Usual Rasidence of Decedant 10a, Stata 10b, County	10	c. City, Towr	n or Location						10d. Inside City Limits
3	be notified at Director	Maryland Prince G	George's (Greenb	elt						1 X Yas 2 No
- 6	or 28a be notifi Direct	10e. Street and Number			10f. Zij	Code			100	. Citizen of What C	Country?
4	23a o met ba	7702 Hanover Par	kway #204	364	20	770			U.	S.A.	- 7
	sr, or lisms 23. Examiner must by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar Armed Forcas? 1 ☒ Yas 2 ☐ No If Yas, Giva Yaar or Datas:	in U,S. WWII	13. Was Dece If Yes, spe 1 Yas			n? (Specify Yas Puarto Rican, at	or No- c.)	14. Race - Am Black, Wh Specify: W	ita, atc.
5-0 72 PG	t, the Medical.	15. Decedant's E	ducation	16a.	Decedent's Usu	al Occu	pation	of warding	16	b. Kind of Busines	s/Industry
24	Med of	Elementary/Secondary (0-12)	Collega (1-4or 5+)		(Give kind of wo						
21 See	4 6	12		Ch	ief Bosy	vain	's Mat	е	N	lavy	
P ST	avent Be G	17. Fathar's Nama (First, Middle, Last	U				18. Mother	s Nama (First, A	Aiddle, Ma	iden Sumame)	THE PLANT OF THE PARTY OF THE P
/lai	Pe go	Wesley John Coop	er				Cora	Frances	DeLo	ittre	
ary sho	e e	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addras	s (Stree	t and Number	or Rural Route I	Number, (City or Town, Stete,	Zip Code)
M Sel	7.5	Kelly A. Derise	- Daughter	7	702 Hand	over	Parkw	av. Gree	enbel	t. Marvl	and 20770
5 - F	00 mg	20a. Mathod of Disposition		Ob. Place of	Disposition (Ne	me of		Data		c. Location - City o	
Pages 1	8 4	1 Burial 2 Cramation 3			y, cremetory or			d1 /10 /	00 4		***
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		+ourt	11/00		4739 1	Balt	imore .	Avenue,	Hyat	tsville,	MD 20781
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Exam	miner	disaasa or condition rasulting in death)	a. Due	to for as a	consequence	00	0.000	1	2010		1
	ě		0	2000	Time	the	2 and	10,11	111		1100
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58.	g physicie as the bu ledical	rasulting in death) Last	Dua	to (or as a c	consequence of):						
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Box death cert	for use										1 -
. 0	9 m	Part II. Other aignificant conditions of	contributing to death but no	ot resulting in	tha underlying	causa gi	ven in Part I.	23b	. Dld tob	ecco une contribu	te to the cause of death?
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Records,	old be				, .		(1)	248	. Was an	autopsy 24b	. Were autopsy findings
S E	page 2 should Completed	possible un	4 Carcer	ma	ame	U,	phill	Lallen	performe	ed?	available prior to completion of cause
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of Vital	certificate rector, pag	25. Was case refarred to medical axaminar?	Magnital:	•		10		of Death (Check	only one)		
Of Physi	E E	1 Yas 25 No		2□ ER/Ou		UA		7	-	ce 6 ☐Other (Sp	vecify)
	After t funera funera tlon:	27. Mannar of Déath 1 Natural 5 ☐ Panding	28a. Data of Injury (Month, Dey Ye		ima of injury	28c. Inju	iry at ork?	28d. Des	cribe how	injury occurred	
Vision Attending or death.	he fe	2 ☐ Accidant invastigation			М	1[]Yes 2□N	0			
Division or Attending	al Director: After the lod in by the funeral Certification:	3 ☐ Suicida 6 ☐ Could not be determined	28e. Place of Injury - building, atc. (S)		rm, street, factor	y, office		28f. Loca City	or Town,	et end Number or i Stete)	Rural Route Number,
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Di Hospital or 24 hours after	Funer lealy fill	29a. Certifier (Check only one) (Check only one) (Check only one)	hyalclan: To the bast of my miner: On the basis of axa and mannar stated.	y knowledga mination and	, daath occurred Vor invastigation	at the t	ime, date and opinion, daath	place, and dua to occurred at that	to the cau tima, dat	sa(s) and manner a and place, and d	as stated. ua to tha cause(s)
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RU	1/1/2	30. Nama and addrass of person who									
0	100	Ravinder Rustagi			over Roa	ad,	Chever	ly, Mary	land	20785-10)22
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			ar y rain		tificate			Mental Hy	Reg. No.	0	2914
1. Decedent's Name (First,		ah a 1 1						2. Date of D Month	Dey	Year	3. Time of Death 4:15 pm
John Sidne 4e Facility Name (If not ins						4	b. City, Town, or	Januar Location of Dee			4.15 pm
5210 42nd P 5. Social Security Number 218–38–8350	6. Sex	M 2□ F 7. Ag	e (In yrs.	last birthday) _ Yrs.	If Under 1	Year Days	Hyattsv If Under 24 Hr. Hours Mir	s. 8. Date of B (Month, D	Prince irth Pey, Year) 21, 1939	g. Birthpi Coun	rge's ace (State or Foreign Land
Usual Residence of Deced	lent County		10c Cit	ly, Town or Loc	ation					10	Od. fnside City Limits
	ince Ge	orgo!c	100.01	Hyatts							1 X Yes 2 No
Maryland Pr	Tirce Ge	orge s		nyacts	101. Zip C				10g. Citizen of V	Vhat Coun	try?
5210 42nd P	lace				20	0781			U.S.A.		
11. Marital Status 1 Never Married 2	X Married	2. Wes Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			/as Deceder Yes, specify		spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or N into Ricen, etc.)	14. Rac Blac Specify	e - America k, White, o	
	ecedent's Educa highest grede		5+)	life. D	ent's Usual (kind of work O NOT use	done d	furing most of w	orking	16b. Kind of Bu		
17. Father's Name (First, M	Aiddle, Last)			-			18. Mother's Na	ame (First, Middl	e, Maiden Surnam		
John Wolfo	rd Can	npbell					Mildr	ed Agne	es Reidy	7	
19a. Informant's Name/Re	lationship (Typ	oe, Print)							ber, City or Town,		Code)
Margaret R. 20a. Method of Disposition 1 ₺ Burial 2 □ Crem			20b. F	5210 2 Plece of Dispos cemetery, crem				Date	Marylar 20c. Location -		0781 wn, State
4 □ Donetion 5 □ Ot	ther (Specify)		F	ort Lin		_		01/20/99	Brentwe	ood,	Maryland
21. Signeture of Funeral S	Service License		Ina.	/ Ga	asch's	Fu	ss of Fecility Ineral H Imore Av	lome, P.A	A. yattsvill	le, M	D 20781
disease or condition resulting In death) Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part ff. Other eignificant conditions	a. b. c.	METAS	Due to (d	or as a consequence as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a conseq	uence of): uence of):	ancr			-1		11 Months
	d.										
Part ff. Other eignificant of	onditions contr	ributing to death b	ut not res	ulting in the un	derlying ceu	use giv	en in Part I.				the cause of death
								24e. Wa	is an autopsy formed?	ave	ore autopsy findings liable prior to appletion of ceuse death?
								1	Yes 2X No	10	Yes 2□ No
25. Was cese referred to n examiner?								eath (Check only	one)		
1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐	Pending investigation	28a. Date of Inju (Month, De	iry	ER/Outpatient 28b. Time of fnjury		c. injun Work	4 🗆 Nuising	-	sidence 6 Oth how injury occur		1)
3 ☐ Suicide 6 ☐	Could not be determined	28e. Place of Inj building, et	ury - At h c. (Specil	ome, farm, stre	et, factory,	office		28f. Location City or T	(Street end Numb own, State)	per or Rura	I Route Number,
29a. Certifier 1 Ca (Check only 2 Me	artifying Phyaledical Examine	cfan: To the best er: On the basis o and manner st	f examina	wledge, death ation and/or inv	occurred at estigation, in	the tin	ne, dete and plac pinion, death oc	ce, and due to the curred at the time	e ceuse(s) and ma e, date and place,	anner as st and due to	ated. the cause(s)
29b. Signature and title of	ced	no	-	/	29c. l	Licens	e number		29d. Date signe	d (Month,	Day, Year)
//	1A	lun	1	7		D24	093		January	20,	1999
30. Name and address of p Mark Parkhur 31. Date filed (Month, Dey, JAN 2 0	st, M.D		Balt	imore A		, #	107, Co	llege Pa	ark, Mary	/land	20740

Letter & white

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** BARBARA A. CUMMINGS 11:08 PM JANUARY 18, 1999 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□ M 20 F 60 241-62-9500 NORTH CAROLINA Director JUNE 30, 1938 Usual Rasidence of Decedant the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County r than "natural", or Nama 23a or 28a-f show the Medical Examiner must be notified at Yas 2 No Director MARYLAND PRINCE GEORGES MITCHELLVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES Funeral 11000 SPYGLASS HILL 20721 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - Amarican Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 72 hours after 1 ☐ Yas 2 📉 No If Yas, Giva 1 Nevar Married 2 XMarried 21215-0020 1 Yes 2 No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry vard Mental Hygiene. 127 is marked other than *: v trsumatic svent Elementary/Secondary (0-12) College (1-4or 5+) BAGGAGE ROOM SUPERVISOR MILITARY 12 Baltimore, Maryland 17. Fathar's Nama (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked other any injury or other traumatic event bates. Be THOMAS HOLMES MABEL HILL 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11000 SPYGLASS HILL, MITCHELLVILLE MARYLAND 20721 JASPER CUMMINGS (HUSBAND) 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State FORT LINCOLN CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 1/23/99 BRENTWOOD, MARYLAND 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility FORT LINCOLN FUNERAL HOME, INC. MOO907 3401 BLADENSBURG RD, BRENTWOOD MD 20722

23a. Part 1. Enter the disease, or complication, that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

April 23a. Part 2. Enter the disease, or complication, that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

April 25a. Part 3. Enter the disease, or complication that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

April 25a. Part 3. Enter the disease, or complication that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

April 25a. Part 3. Enter the disease, or complication that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

April 25a. Part 3. Enter the disease, or complication that sused the death. Approximata Intarval Between Onset and Death **Physician** /Medical Immedieta Ceusa (Final disaasa or condition rasulting in death) Examiner Examiner notas ta ician and burial-transit tha death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated evants resulting in daath) Last physician s the burial Box 68760, Physician/Medical Dua to (or as a consequence of) 88 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Obstrution Records, þ 24b. Ware autopsy findings available prior to 24a. Wes an autopsy performed? Completed complation of cause of death? The 20 No of Vital 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 9 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar Division or Attending Natural 5 Panding Invastigation s after dea. 1 Yes 2 No 2 Accident 6 Could not be datamined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital o within 24 hours at To the Funerel Di completaly filled is Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. edical (Check only 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 38013 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) N. FREDERICK AVE, GATHERBURY, MO 10-A NACH SHAMKHAN) -501 32 Registrar's Signatura 31. Data filed (Month, Day, Year) State JAN 2 2 1999

DHMH 16 Ray 6/95

Registrar

5 1 2 2 898 June 1 1 James

State of Maryland / Department of Health and Mental Hygiene

					Olalo	or ividiyio				Death	IIG IV	eritai riyg	Reg. No.	0.	2916	
П	Dhuniai		1. Decedent's Name (Firs	t, Middle, L	ast)							2. Date of Dea Month	_	Year	3. Time of Deal	th
	Physici /Medi		Flora Jea		emond							January			19:25	
	Examir		4a. Facility Nama (If not in	stitution, gi	ve street and nu	ımber)		,		4b. City, Tow	m, or Lo	cation of Death	4c. County	of Death		1
			Union Hospi				4	611		E1k				Cecil		
	Funeral		5. Social Security Number		Sex 1□M 2⊠F		rs. la <i>st birthday,</i> Yrs.	If Under Months			Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or For try)	
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	/land	7		County		10c.	City, Town or L	ocation						1	0d. Inside City Lir	nits
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	th the	Director	10e. Street and Number					10f. Zip					log. Citizen of	What Coun	itry?	_
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	ems er m	Funeral	11. Maritai Status	J. 3. E. 11 A.		edent Ever in	U,S. 13.	Was Dece			in? (Spe	cify Yes or No- Rican, etc.)	14. Rac	e - Americ	an Indien,	
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5-0	d within 72 ho liene. r than "natur r e Medical	Completed	15. D (Specify onl	ecedent's E	ducation ada completed)		16a. Dece	dant's Usus	al Occup	pation during most o	of workin	90	16b. Kind of B	usinass/inc	dustry	
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E			1 XBurial 2 ☐ Crer 4 ☐ Donation 5 ☐ C				orth Ea	-			J	an. 23	North I	Foot	Marylan	a
Baltimore,	permit. Page Depertment Important: If any injury or once.		21. Signature of Funarai	ervice Lies	ryes)	-	2	2. Name an	d Addre	ss of Facility		1999	NOI CII I	Last	Marylan	α
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 1135A.M. Barbara Jean Dace JANUARY 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death LIVINGSTON RI PRINCE GEORGES APT#300 HILL UXON If Undar 24 Hrs. 8. Data of Birth (Month., Dev. 6/26/49 If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) Days Hours 1 ☐ M 2 1 F Months 326-44-7393 49 St. Louis, MO. Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. insida City Limits 1 ☐ Yas 2 ☑ No Maryland Prince George's Oxon Hill 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6435 Livingston Rd. #302 20745 USA 12. Was Decedant Evar In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Maritel Stetus Black White atc. Yes 2XXNo 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced Year or Datas: 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elamantery/Secondary (0-12) Collaga (1-4or 5+) Claims Processor&Receptionist Blue Croos Blue Sheild 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Swinton Hugh Hairston Elsie Orr 19a. informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Henry H. Hairston/Brother 1740 Rhodesia Ave. Ft. Washington, MD. 20744 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition Date cematary, cramatory or other place) 1 Buriai 2 Cramation 3 Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Sunset Gardens of Memories 1/23/99 Millstade, Illinois 21. Signalung Funaral Sarvice Licensaa 22. Nama and Addrass of Facility George P. Kalas FunerAL Home, P.A. aldo 6160 Oxon Hill Rd. Oxon Hill, MD. 20745 Part 1. Entar tha disaasa, or complicetions have aused the death. Do not entar the mode of dying, such as cardiec or respiratory arrast, shock, or heart failura. List only one cause or each line. Approximata intarval Between Onsat and Death immediata Causa (Finai & HYPERTENSIVE ARTBRIOSCLEROTIC CARPIOVASCULAR DISEASE disease or condition rasulting in daath) AND CHRONIC RENAL FAILURE Sequentially list conditions, if any, leeding to immediate causa. Entar Undarlying Ceusa (Diseasa or injury that initiated events rasulting in deeth) Last Due to (or es e consequence of): Dua to (or as a consequance of): Part II. Other aignificant conditions contributing to death but not rasulting in the underlying ceuse given in Part i. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings available prior to 24a. Was an eutopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Siata

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Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be Certification: To

The law requires that the death certificate be executed physicien and s the burial-transit P.O. Box 68760 d for use es the ed by th been signed should be det Division of Vital Records, hes page certificate Hospital or Attending Physician: director. this funeral After death. rector: / Direc

To the Hospital or within 24 hours aft To the Funeral Di complataly filled in Medical

29a, Certifier

State Registrar

completion of causa of death? 1 Yas 2 No 1 Yas 2 No 25. Was cesa referred to medicel exeminer? 28. Placa of Death (Chack only ona) 1 Yas 2 No Other: 4 □ Nursing Homa 5 Rasidance 6 □ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Megnar of Death 28a. Data of injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Tima of 28c. injury ai Work? 1 Netural 5 Pending 1 ☐ Yas 2 ☐ No 2 Accidant invastigation 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stefa) 28a. Place of injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basts of axamination end/or investigation, in my opinion, deeth occurred at the time, deta and place, and due to the cause(s) and manner stated.

29b. Signature 29d. Data signad (Month, Day, Year) 29c. Licansa number

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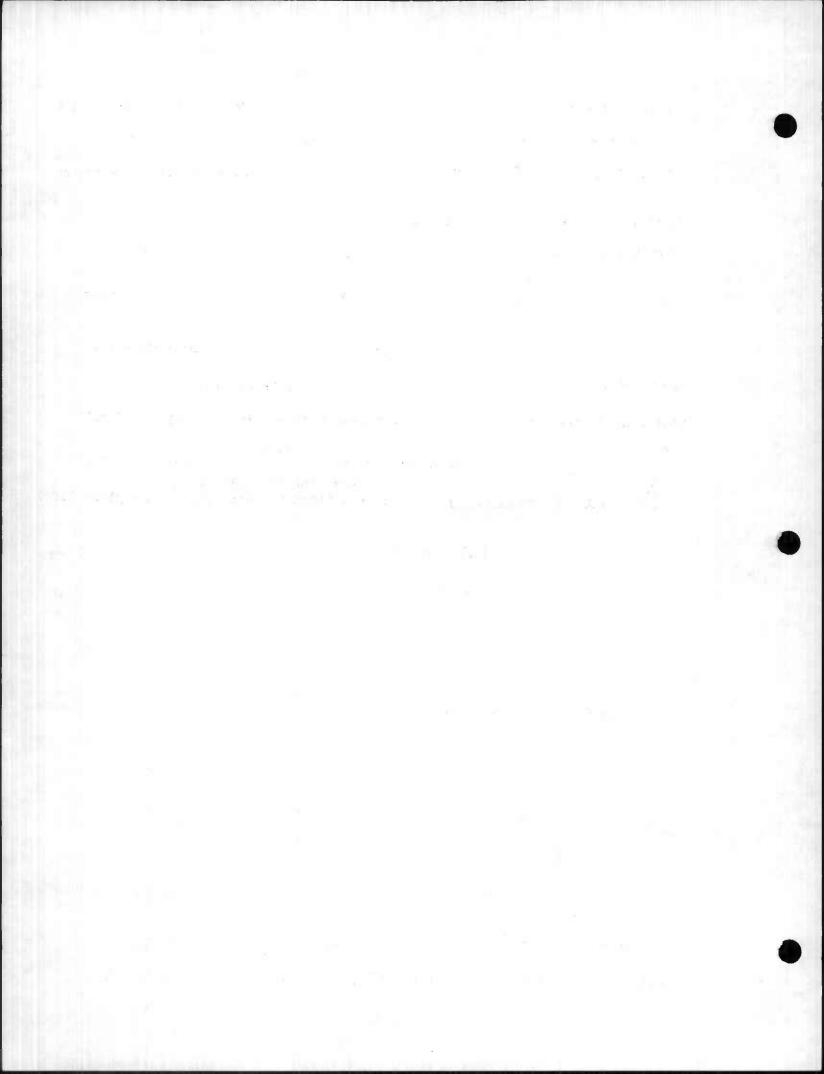
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2. Registrar's Signatura

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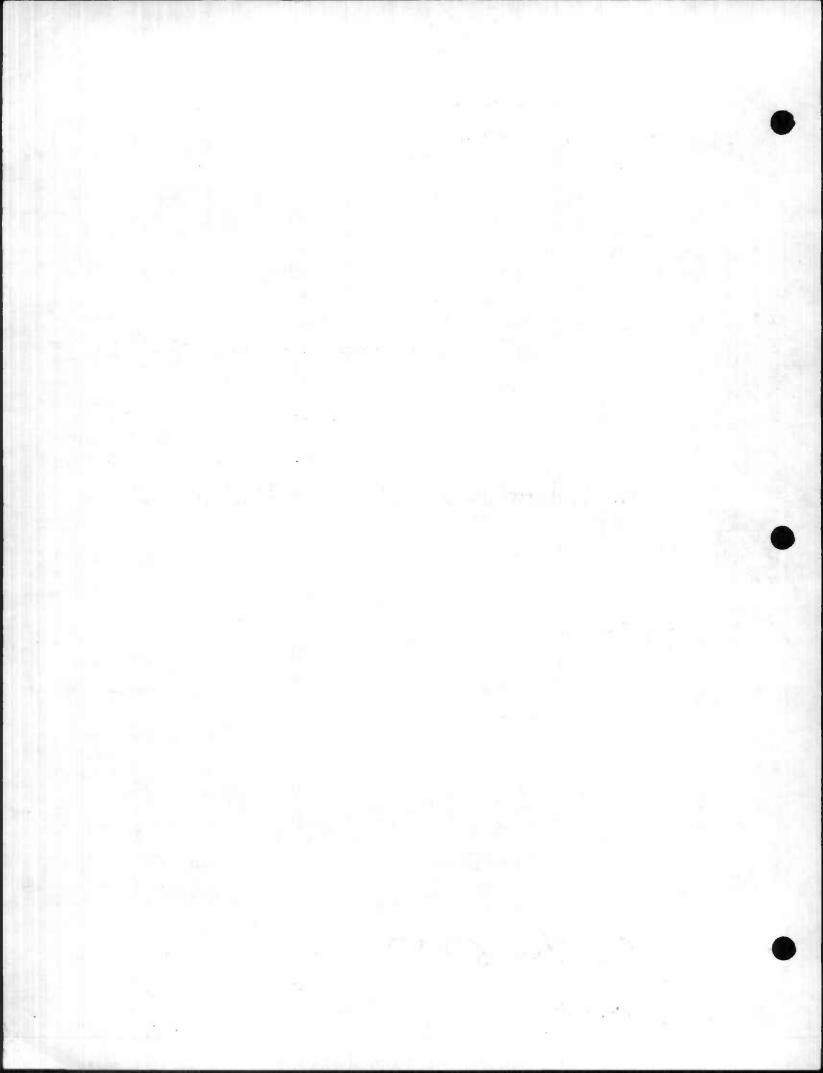
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** January 19, 1999 Viola M. Esler 2110 /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Manor Healthcare Cecil Rising Sun Hours Min. April 10, 1911 Sew Jersey If Under 1 Year 5. Social Sacurity Numbar 7. Aga (In vrs. last birthday) **Funerai** Days 1 □ M 2 1 F 87 Director 113-24-7050 Usuel Rasidanca of Dacedant with the Maryland would ! 10b. County 10c. City, Town or Location 10d. Insida City Limits an "natural", or items 23s or 28s-f show Medical Examiner must be notified at Funeral Director 1 Yas 2 No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 21911 1221 Calvert Road United States death 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritel Status 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 Never Married 2 Marriad Baltimore, Maryland 21215-0020 White 1 ☐ Yas 2 X No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Year or Datas: Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) al Hygiene. I other than " vant, me Me Elamantary/Secondary (0-12) Collega (1-4or 5+) Bell Telephone 12 Operator 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Pages 1 end 2 should be nent of Health end Mental 27 is marked or traumatic evi John Bell Kathrine Bierley 2 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 end 2 Department of Health e Important: if Item 27 is eny injury or other tra 677 Nottingham Road, Elkton, Maryland 21921 Ronald N. Esler/ Son 20b. Place of Disposition (Nama of cematary, cramatory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata January 29, 4 ☐ Donation 5 ☐ Othar (Spacify) 1999 Calvert, Maryland Rosebank Cemetery 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Hicks Home for Funerals, P.A. 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. West Stockton Street, Elkton, Maryland 21921 Approximata Intarval Batween Onset end Death **Physician** Immediata Causa (Final disease or condition resulting in daath) /Medical NEUMONIA 5 days Examiner Dua to (or as a consequanca of): Examiner ATTURMENTER The law requires that the death certificete be executed burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or es e consaquance of): Box 68760. Physician/Medical the Dua to (or as a consaquance of): 98 USB 10 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown MABETES MELLITUS Records. þ page 2 should 24b. Wera autopsy findings aveileble prior to Completed 24a. Was an autopsy performed? completion of causa of death? certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital Attending Physician: director, Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 2 1 Yas 2 1 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Manne of Death Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred After Division 1 Natural 5 Panding invastigation deeth. 1 ☐ Yes 2 ☐ No 2 Accidant efter deeth 3 Suicida 6 Could not be 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 6 the Hospital within 24 hours of To the Funeral C 12 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medicai completely 29b. Signatura and titla of certifia 29c. Licansa number 29d. Data signed (Month, Day, Yaar) MID 30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print) WARROLTON RID ELLION MIS 901 RENZULL Willym 31. Data filad (Month, Day, Year) 32. Ragistrar's Signatura State JAN 2 2 1999 Registrar

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Physician /Medical	Decedent's Name (First, Middle, La Rus	ssell Ehrhard	dt			2. Date of Dea Month JANUAR	Day	3. Tima of Dea 999 8:50 A
Examiner	4a Facility Name (If not Institution, gir	ve street and number)		4	lb. City, Town, or L	ocation of Death	4c. County	
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uneral irector	107-05-2944	Sex 7. Aga (In 1 M 2 □ F 8	yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De) Feb. 2.	Year) 3,1911	9. Birthplace (State or For Country) New York
	Usual Residence of Decedent 10a. Stata 10b. County	10	c. City, Town	or Location			Sec. 1	10d. Inside City Li
and and		cil			Elkton			1 ☐ Yes XI
north north	10e. Street and Number			10f. Zip Code			10g. Citizen of V	/hat Country?
T Di	250 Greenwood Str	reet			21921			S.A.
iner met be notified	11. Marital Status	12. Was Decedent Ever	r in U,S.	13. Was Decedent of H If Yes, specify Cubi	ispanic Origin? (Sp	ecify Yes or No-	14. Race	- American Indian,
0 9	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Yaar or Dates: 194	49-53	1 ☐ Yes 2 🏋 No	Specify:	Hican, etc.)	Specify	k, White, etc. White
matural En	15. Decedent's E		16a. C	Decedent's Usual Occup	ation	ina	16b. Kind of Bu	
nple and	(Specify only highest gr Elementary/Secondary (0-12)			ife. DO NOT use retired	9		U.S. Army	Provinc Cround
Completed		College (1-4or 5+) Two Years	Me	chinical Engir		1		Proving Ground Maryland
Be Be	17. Father's Name (First, Middla, Las				18. Mother's Nam		Maiden Surnam	θ)
TO B		lam Ehrhardt				ia Daum		
Item 27 is m other traun	Ruth A. Ehrhardt	(Type, Print) (wife)		Mailing Address (Street) Greenwood				
r oth	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐		Ob. Place of Cometery,	Disposition (Name of crematory or other place	oe)	Date	20c. Location -	City or Town, State
mportant: If any injury or ance.	4 Donation 5 Other (Speci	fy)	R.A. Fe	rris & Co.	Inc. 1	/20/99	West Ches	ster, Pennsylvan
impo any i ance	21. Signature of Funeral Service Lice 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or con	attersox,	Sc.	22. Name and Addres Lee A. Par Perryville	tterson & e, Maryla	nd 2190	03-0188	Approximate
edical aminer	Immediate Cause (Final disease or condition resulting in death)	e. PNEUMONIA		nsequence of):				Onset and Deet
hysician and the bunal-transit dical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury	b	to (or es a co	nsequence of):				T T
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e attending ed for usa a sician/Me	Part II. Other significant conditions	contributing to death but no	ot resulting in t	he underlying cause niv	en in Part I.	23b. Did t	obacco use cor	ntribute to the cause of de
Physician			ot resulting in t	he underlying ceuse giv	en in Part I.		obecco use cor /es 21XNo	ntribute to the cause of de
be detached for by Physicia	Part II. Other significant conditions of CEREBRAL VASCULAR		ot resulting in t		en in Part I.		A1-6-11 1-3-4-	3 Probably 4 Unk
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State of Maryland / Department of Health and Mental Hygiene

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	5. Social Security N	lumber (6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1		If Under		8. Date of B				aca (Stata or
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	3 ☐ Widowed		If Yes, Gi	ive		1 ☐ Yes 2	No M	Specify:				Specify:	B1a	ck
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T	23a. Part1. Entar ti shock, or hea	ha dispass, or c	omplications that	caused the death	. Do not ent	ter tha mode	of dying	, such as	cardiac	or respiretory	arrest,			Approximata Inlarval Batwe
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DHMH 16 Rev 6/95

JAN 1 8 1999 STRAL

State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Mary Mack Graham .29 Am 15 1999 4c. County of Deeth 4b. City, Town, or Location of Death /Medical 4a Facility Neme (If not institution, give street and number) **Examiner** Washington Adventist Takoma Park Montgomery Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 14,1912 So. Carolina 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) If Under 1 **Funeral** Days Months Hours 200-18-5349 1 □ M 2 XF 86 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahor tre Medical Exerciser must be notified as 1 Ves 2 No Director Maryland Prince George Hyattsville 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6405 20783 8th Avenue USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Black, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 ☐ Merried 21215-0020 Specity: Black 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Hygiena. Seamer (Campbell Soup Co) Private . Pages 1 and 2 should be filed w tment of Health and Mental Hygie lant: If itam 27 is marked other to jury or other traumatic avent, to Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Graham Mack Claricy Roberson 19a. Informant's Name/Relationship (Type Print) Georgia M. Haile (Niece) 19b. Malling Address (Street and Number or Ryral Route Number, City or Jown. State Zip Code) 6405 8th Ave. (Hyattsville, Md. 20783) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 【 Removal from State permit. Page Department of Important: If any Injury or 1/22/99 Saluda, S.C. □ Donation 5 □ Other (Specify) Pleasant Hill Cem. 22. Name and Address of Facility
Jordan Funeral Service, Inc.
4001 Benning Rd., N.E. (Wash., D.C. 20019) 21. Signature of Fuperal Service to cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or cause on each line. 23a. Part1. Enter the disease, or complic shock, or heart feilure. List only one Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pur Box 68760. TRACT The law requires that the death certificate be Physician/Medicai Due to (or as a consequenca of) the ANGRERE USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco uas contributs to the causa of death? à 1 Yas 2 No 3 Probably 4 Unknown should be det Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 2 No certificata 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 HO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aftar 1 PNatural 5 Pending investigation ve Hospital or Attanding in 24 hours after death. The Funeral Director: Afte 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

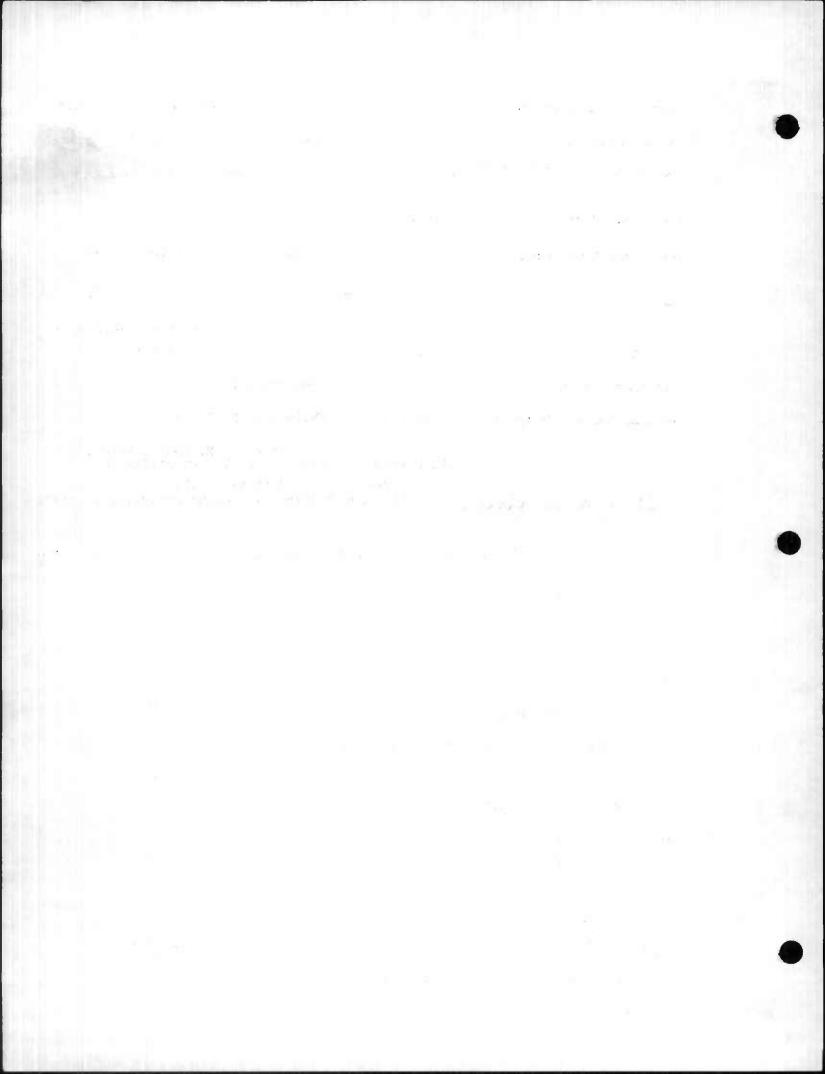
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai compietaly (Check only one) Within 2 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8121 GEORGIA AVE, #405 SI WER SPRING, CARLOS E. COVARRUBIAS M.A. 2. Registrar's Signature 31. Dete filed (Month, Day, Year) State JAN 1 9 1999 Registrar

DHMH 16 Rav 6/95

35 miles 1999 1 1991 1 1991

·-				State of Maryla		tificate of			giene Reg. No. 99	0 8	2922
	Physici	an	Decedent's Nama (First, Middle, La	est)				2. Data of Dee Month		Year	3. Tima of Death
	/Medi		James Nicholas H					January		99	0530
1	Examir	ner	4a. Fscility Nama (If not institution, git Union Hospital	a straat and number)			4b. City, Town, or L Elkton	ocation of Death	4c. County o		
Н	Funerai			Sax 7. Age (In y	rs. last birthday)	If Under 1 Year	If Undar 24 Hrs.	8. Data of Birtl	h .	9. Birthple	aca (State or Foreign
	Director		065-09-6086	№ M 2□ F 94	Yrs.	Months Deys	Hours Min.	June 4,		Countr New Y	
_	pu ,		Usual Residence of Decedent	10:							
	shov	_	10a. Steta 10b. County		City, Town or Loc					10	d. Insida City Limits 1 Yas 2 □ No
	the Marylan 28a-f show	ecto	Maryland Cecil	NC	orth East						
	with the party of	늅	10e. Street and Numbar	D 3		10f. Zip Coda	21901	,	10g. Citizen of W United		•
	ns 23a	eral	801 River Manor	12. Was Decedant Evar in	IIS 13 V	Vas Decedent of I	dispanic Origin? (Sp	pacify Vas or No-			
21215-0020	within 72 hours after death with the Maryland iene. than "naturel", or items 23a or 23a-f show the Medical Examiner must be notified at	by Funeral Director	1 Never Merried 2 Married 3X Widowad 4 Divorced	Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Datas:	If	Yas, specify Cub ☐ Yas 2X No	an, Maxican, Puerto	Rican, atc.)	Bleck Specify:	Whita, a	tc.
5-0	natural',	eted	15. Decadent's E (Specify only highest gr	ducation	16a. Deced	ant's Usual Occup	pation during most of work	kina	16b. Kind of Bus		
121	C 1 60	Completed	Elementary/Secondary (0-12)	Collega (1-4or 5+)	lifa. D	O NOT usa retire	d)		Packing Tetley T		renent
7	filed withir Hygiene. other than		8 17. Father's Nema (First, Middla, Last	11	Packe	r	40 14-15-1-15				
Maryland	od ta b	To Be	Nicholas Harlow	,			Margare		<i>Maidan Sum</i> ama	,	
ary	shou ind M i mer	-	19a. Informant's Neme/Ralationship	Type, Print)	19b. Mailin	g Addrass (Street	and Numbar or Ru	ral Route Numba	r, City or Town, S	itata, Zip C	Coda)
	and 2 saith a n 27 is		Joan M. Morgan/	Daughter	P.O.	Box 33,	Childs, M	Maryland	21916		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 is marke any Injury or other traumatic. once.		20a. Mathod of Disposition 1 ☐ Burial 2 ⚠ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Ramoval from Stata		sition (Nama of latory or other pla is and C	Janu		20c. Location - C West Ch Pennsylv	este	
alt	Departi Departi Importa any Inju		21. Signature of Funeral Service Lica				iss of Facility		_		
00	805 2 9		Donald	8. Hick			tockton S			rylar	nd 21921
-			23e. Part1. Entar tha disaasa, or com shock, or heart failure. List only	plications that causad the d	eath. Do not ante	r tha mode of dyi	ng, such es cardiec	or raspiretory ar	rast,		Approximata Intervel Batween
	Physician /Medicai Examiner		Immediata Causa (Final disaasa or condition rasulting in death)				PARCO				Onset and Death
		Jer		Due to	o (or as a consequ	uence of):					
	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions,	b. Dua to	o (or as a consequ	uance of):					
68760,	be ex ician burial		Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disease or Injury	C							
387	cate phys s the	edicai	that initiated events resulting in deeth) Last	Dua to	(or as a consequ	ianca of):				I	
Box (attending	N/		d							
m	atter d for u	cial	Part II Other plantiles at a multiple a		to the second second	1-11		T and miles			
P.O.	tt the de by the a tached	Physician/M	Part II. Other significant conditions of		rasulting in tha un	danying causa gr	van in Part I.	236. Did 1			the cause of death?
e,	es that igned I be det	by P	1 IVEWY	over				101	2010	3_110be	ibiy 4 dikilowii
of Vital Records,	law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the bunal-transit	Completed I	CONGES.	TWE HEM	er FA	wre		24a. Was a	an autopsy mad?	avai	ra autopsy findings labla prior to apletion of causa
Rec	0 - 5	ldu								of de	eath?
B	ician: The la certificate ha rector, page	e Co	Or Western Manual Assessment					1 🗆 Y		1 🗆	Yes 2□ No
S		0 8	25. Was casa referred to medical examinar? 1 ☐ Yes 2 No	Hospital:	□ EB/0-4-484	Ott	26. Pleca of Dea			10	
0	Phys arthis eral d		27. Mannar of Death	28a, Date of Injury	☐ ER/Outpatient 28b. Time of	3□ DOA OII 28c. Inju Wo	4 🗆 Nursing n		enca 6 Othai ow Injury occurre		
io	Attending For death. Sector: After by the funer	atio	1 □ Natural 5 □ Panding 2 □ Accident Invastigatio	(Month, Day Year,) Injury		rk? Yas 2 □ No				
Division	er der recto by th	Certification:	3 Sulcide 6 Could not be determined		t homa, farm, stre	at, factory, office		28f. Location (S City or Tow	treet and Number	r or Rural	Routa Number,
	rs afte al Dir	Cer		ounding, ato. (ope	ony/			Ony or You	n, olate,		
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Cartifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my k ninar: On the basis of axam and manner stated.	nowladga, daath ination end/or Inv	occurred at the til astigation, in my o	me, dete and placa, opinion, deeth occur	and dua to the d rred et the time, d	ause(s) and men deta and placa, ar	ner as ste nd dua to t	ted. tha cause(s)
	vithin 2 To the	M	29b. Signatura and title of partiar			29c. Licens	se numbar	-	29d. Date signed		ay, Year)
			Munk	miD		04	4102		1/16/99		
	3		30. Nama and address of parson who	complated cause of deeth (I					0.04		
			WILLIAM RENZ		ARBURTO	US W	FULTON	MP	21521		
	Sta Registr		31. Dete filed (Month, Day, Year) JAN 2 0 1999	32. Registrar's Sig	gnature	/					

DHMH 16 Rev 6/95



99-0287-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

W	ANDA ENDERSO	N	ITEMS: #23 PART I, 27	State of	of Marylan	d / Dep	artment	of H	lealth and	Mental Hy	/gieneg g		923
	Physici /Medi	an cal	WANDA DE	NISE HE	ENDERSON					2. Dete of D Month JANUAR Location of Dea	Day Y 19,19	Year 1	3. Time of Death 2:10P.M.
	Examir	er	4a Facility Neme (If not institution, g WASHINGTON ADVEN		2022				TAKOMA I	PARK	MONTO	y of Death	
	Funeral Director		578-82-5044	Sex 1□M 2∏ F	7. Age (In yrs. 23	last birthday) Yrs.	If Under Months	Year Days	Hours Mi	n. (Month, D	irth ay, Year) +, 1975	9. Birthplac Country Washi	ce (Stete or Foreign ngton, DC
	Manyland 4 show	lor	Usual Residence of Decedent 10a. Stete 10b. County			y, Town or Li hingto						10d	I. Inside City Limits
	h with the 13e or 28e	Funeral Director	10e. Streel and Number 1137 Stevens Roa	ad. S.E.			10f. Zip		0		10g. Citizen of	What Country State	
020	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Exercitive must be modified at	by	11. Meritel Slelus 1X Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Dec	cedent Ever in U orces? 2X No ive	,S. 13.	Wes Decede	int of the		(Specify Yes or Norto Rican, etc.)	0- 14. Ra Ble	ce - American eck, White, etc	Indian,
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s, P.O.	that the cled by the detached	by Physician/M	Pert II. Other algnificant conditions	contributing to d	leath but not res	ulting in the u	enderlying ca	use gi	ven in Part I.		i tobacco use c] Yaa 2□ No		he cause of death? bly 4 Unknown
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>		To Be	examiner? YXYes 2□ No	Hospitel:	Inpatient 2	ER/Outpatie	nt 3 DO	Ott	ner _	Home 5 Res		ther (Specify)	
Division of	fing Ph. After thi Iuneral		27. Manner of Death 1 Netural 5 Pending investigati	28a. Date (Moi		28b. Time of Injury		c. Inju Wo		7	how injury occu		
DIVI	교육	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 200. Plac	e of Injury - At h ling, etc. (Speci	ome, farm, st	reet, fectory,	office		28f. Location City or To	(Street and Num own, State)	ber or Rural F	loute Number,
	To the Hospital or within 24 hours aft To the Funeral Dir completely filled in	edical		aminer: On the b						ce, end due to the curred at the time			
	with! To th	Σ	29b. Signeture and title of certifier	11			29c.	Licens	se number		29d. Date sign	ed (Month, Da	ly, Year)

State Registrar 2. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

JANUARY 20,1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Data of Death 3. Time of Death 8:44 Am 14 Januaru 1999 Vanessa Hammond 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctors Hospital Lanham if Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Months Days Hours 1 M 2 XF Yrs. 45 577-66-0317 Washington, D.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 USA 15005 Health Care Center Drive 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No Specify Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent'a Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Assistant Private 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Unknown Zelda Dorsev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Herbert Hammond / Husband 9008 Ivanhoe Rd. Ft. Washington, Maryland 20744 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 1-17-99Alexandria, Virginia Metropolitan Crematory 21. Signatura of Funeral Sarvice Licensee 22. Nama and Address of Facility Alexander S. Pope Funeral Home 23a. Part failure. List only one cause on each line.

23a. Part failure. List only one cause on each line. 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Betw Congestive heart failure Immediete Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Corony arty discon 24b. Were eutopsy findings availabla prior to completion of cause of death? insulin dependent diabetes 24e. Wes an autopsy performed? peripherel vascular dis 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Items 23s

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filed within 7 Hyglene.

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Pages 1 and 2 should by ment of Health and Menta lant: If them 27 is marked lary or other traumatic en

Department of Important: If its any injury or o

Director

Funeral

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Completed

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Box 68760. P.O. Records, Division of Vital or Attending Physician: funeral After after death. filled in by

Examiner Physician/Medical Completed by Be Certification: To

Mospital 6 plataly To the lithin 2

> State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Hiller V. W. road BZ16 BowiE MO 20716 31. Date filed (Month, Day, Year) JAN 1 9 1999

5 Pending

investigation

Routen Fanher

6 Could not be determined

27. Manner of Death

2 Accident

4 Homicide

(Check only one)

29b. Signature end title of cartifier

3 ☐ Suicide

29a. Certifier

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

28b Time of

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

29c. License number

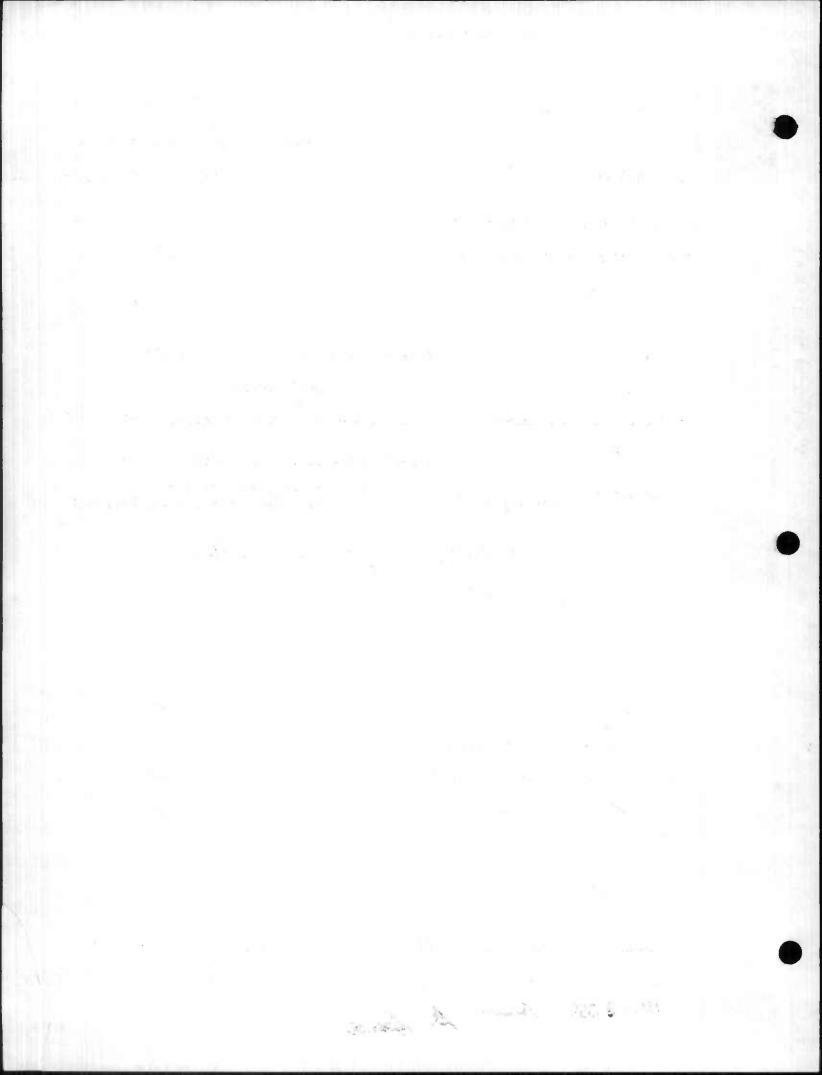
1 ☐ Yes 2 ☐ No

D43446

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 7 And **Physician** 1058hrs. 48 JOON /Medical 4b. City, Town, or Location of Deeth 4a. Facility Neme (If not institution, give street and number) 4c. County of Death Examiner HOSPITAL BALTIMORE BALTMORE ST. AGNES If Under 1 Yaar If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, **Funeral** Months 1 M 2 □ F 9 6 Yrs. NONE Director Usual Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits 10a. Stete r than "natural", or items 23a or 28a-f show the Medical Examiner nast be notified at 1 ☐ Yes 2 No Director None Grea NONE Q. N. 9 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 14. Rece - Americen Indian, Black, Whita, atc. UNAVALL 326 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 11. Marital Status efter 1 Never Marriad 2 Merried 1□ Yes 2 No Specify: þ ASIGN 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) armer 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liqury or other traumatic event page. 17. Fether's Neme (First, Middle, Last) Ham DUNG 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) Dany-Nigger MD William De Balt. 3 reaya 1516 KING 20c. Location - City or Town, State 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovel trom Stete 4 ☐ Donetion 5 ☐ Other (Specify) JAN 18,89 rem. 22. Name and Address of Facility Dh. 11:0 Bell Fun. Ser. 20748 21. Signature of Funerel Service Licensee Bell Hoven St, TempleHills, MD 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between **Physician** immediate Cause (Final disease or condition resulting in death) /Medical RRAIN STEM HEMORRHAGE SIX DAYS Examiner Due to (or es e consequence of): Examiner SIX Y FARS HYPERTENSION ettending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of causa ot death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2D No 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 10 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident

JOON N NAME: HAM, KYE

Baltimore, Maryland 21215-0020

the death certificate be exec Box 68760,

24 hours To the Hosp within 24 hou To the Fune completely fi

State Registrar

29b. Signeture and MEDICAL RESIDENT

6 Could not be determined

3 Suicida

29a. Certifier

edical

4 Homicide

(Check only one)

31. Date tiled (Month, Dey, Yeer)

JAN 1 9 1999

P11702

15d Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) end menner steted. 29d. Date signed (Month, Day, Year)

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Neme end address of person who completed cause ot death (Item 23e) (Type, Print) C-MBONU,

900 CATON AVE, BALTIMORE MD 21229

2. Registrer's Signeture

Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify)

STATES NO.

State of Maryland / Department of Health and Mental Hygiene 0 02926

						Cei	rtificate (of Death		Reg. No.	0 (11)	La Contract
	1. Dec	edent's Name (First, M	iddle, Las	t)					2. Dete of D	eeth		Time of Death
Physicia	Ι Δ Κ	OLINA		C.			HE	NDERSON	JANUAF	Day 13. 1	Year 999 10	0:17 A.M
/Medica	do Fo	cility Name (If not instit	ution, give		ber)				or Location of Dee			J. I / A.N
Examine Funeral Director	17 5. Soci	228 SANDY 1 al Security Number 9-05-3823 Residence of Deceden	6. Se		7. Age (In yrs.	last birthday) Yrs.	If Under 1 Y Months D		in. (Month, D	rth	GOMERY 9. Birthplace Country) VERMOI	(Stete or Foreign
anyland ahow	10e. S	tete 10b. Cou	inty		10c. Cit	ly, Town or Lo	cation				10d. le	nside City Limits
the M	8	YLAND MON'	TGOME	RY COUN	TY O	LNEY	10f. Zip Co	de		10g. Citizen of		☐ Yes 2X No
th with	172	28 SANDY K	NOLL	DRIVE			208	332		UNITED	STATES	
020 urs attar dea si', or items	1 1 2 3 5	rital Status] Never Married 2□ ¶ Widowed 4 □ Divo		12. Was Deced Armed Ford 1 Yes : If Yes, Give Year or Da	ces? 2 🔯 No		Wes Decedent if Yes, specify 1 ☐ Yes 2 ☒	of Hispanic Origin? Cuben, Mexicen, Pu No Specify:	(Specify Yes or N erto Ricen, etc.)		ce - American in ck, White, etc. y: WHITE	
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Baltimore, pemir. Pages 1 er Department of Hea important: If Nem; eny injury or othe	21. Si	gneture of Funeral Sen	ige Licens	590				ddress of Fecility COLN FUN	ERAT. HOME			
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CONTRACTOR	Je Je			CORON		TERY D					1	YEAR
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x 687 entificate ling physicate as the		ng in death) Lest			200.00(0		,50,100 0.7.				4	
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death death he atten	Pert II.	Other significant con	ditione co	ntributing to dea	ath but not res	sulting In the u	nderlying caus	e given In Pert i.	23b. Did	l tobacco uss co	entribute to the	cause of death
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Records,	Completed								24e. We	s en eutopsy lormed?	eveileb	utopsy findings ele prior to etion of cause h?
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DIVIS saftard	4[termined	28e. Piece	of Injury - At h g, etc. (Special	ome, farm, st fy)	reet, fectory, of	ffice	28f. Location City or T	(Street and Num own, Stete)	ber or Rurel Ro	ute Number,
he Hospi in 24 hou he Funer pletely fil	29a. C				sis of exemine		vestigetion, in	he time, date end pl my opinion, deeth o		, date and plece	and due to the	cause(s)
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DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 9 1999

State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Helen Clara Holloway 19, 1999 January 8:15 am /Medical 4a Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6901 Ingraham Street Prince George's Riverdale If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Hours Months 577-62-4687 90 Yrs Director 1908 Washington, DC Usual Residence of Decedant 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits appa 1 Was 2 No Directo Maryland Prince George's Riverdale 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? natural", or flams 23s or 6901 Ingraham Street 20737 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status Black White etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 Nidowed 4 Divorced White Year or Dales: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Arlington National Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cemetery Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumema) permit. Pages 1 and 2 should be tilt Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other treumatic even Be William Loeffler Anna Clara Hubner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James Holloway - Son 5700 Saint Bernard's Drive, Riverdale, MD 20737 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/23/99 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 lesson 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical CARPINOMA ZIZOT 5 F ABDOMEN. 3 montes Examiner Due to (or as a consequence of): Examiner PRIMARY 72 KNOW physicien and the burial-trensit tha death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 980 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 ☐ Yea 2 No 3 Probably 4 Unknown Records, P 24b. Wera autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 1 Yes 2 K No 1 Yes 2 No certificate Division of Vital or Attending Physician: after death. director. Be 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Matural 5 Pending 1 ☐ Yas 2 ☐ No Investigation neral Director: / 2 Accident 6 Could not be detarmined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 124 hours a Hospital 29a. Certifian 🞢 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. (Check only one) To the P within 24 To the F complete 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number January 21, 1999 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) K. Joseph Mathew, M.D. 6510 Kenilworth Avenue #1400, Riverdale, Maryland 20737 32. Registrar's Signatura 31. Data filed (Month, Dey, Year) State JAN 2 2 1999 Registrar

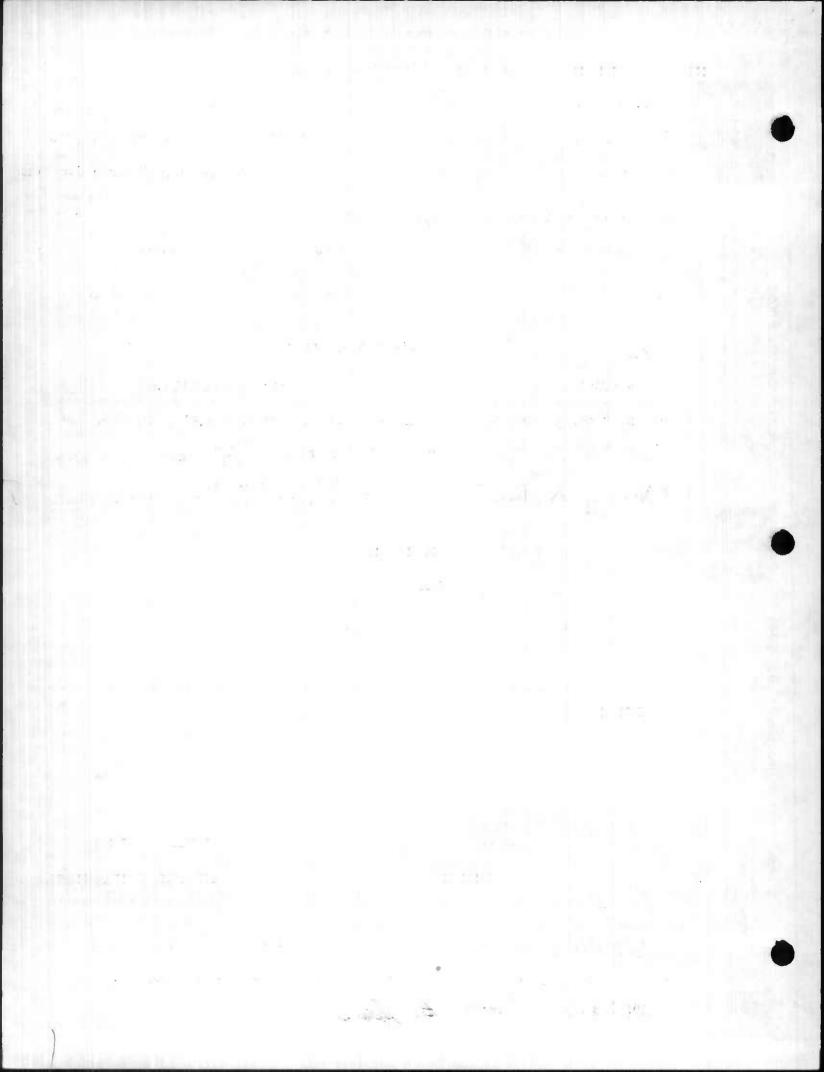
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State of Manuard / Department of Health and Mental Hyriana

an	MS: #23 PART I, II, 27 1. Decedent's Nama (First, Middle, Les HERBERT W. JE		Per pla		15,0		2. Data of De	Day	Yaar	Tima of Deeth
	4a Facility Name (If not institution, give					4b. City, Town, or	Januar Location of Deet	9		0:12 PM
er	6221 Lee Place 5. Social Security Number 250-01-5518 6. Sr		(In yrs. last birtho	Months	r 1 Yaar	Capitol If Under 24 Hrs. Hours Min.	Heights	Prin	9. Birthplace	(State or Fore
	Usuel Residance of Dacedent 10a. Stata 10b. County		10c. City, Town of	or Location					10d.	Inside City Limi
5	Maryland Prince G	eorge's	Capito	ol Heio	hts					1 ☑ Yas 2 ☐ N
al Director	10e. Street and Number 6221 Lee Place				Coda 2074:	3		10g. Citizan of V	Whet Country?	
	11. Maritei Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forcas? 1 ☐ Yas 2 ☒ No if Yas, Giva Yaar or Datas:	- 4	13. Was Dace If Yas, spe 1 Yas	cify Cubi	lispanic Origin? (S en, Maxican, Puerl Specify:	pecify Yas or No o Rican, atc.)	Blac	e - American I ck, Whita, etc. v: Black	
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	James Jenkins					Cathe	rine J	enkins		
	19a. Informant's Name/Ralationship (7	Type, Print)	19b. N	Aailing Addras	s (Streat	end Number or Ru	ural Route Numb	per, City or Town,	Stata, Zip Co	da)
H	Mary H. Robinson	/Daughter				e, Capit				
	20a. Mathod of Disposition 1 □ Bunial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of D comatary, Harmon	y Memo	rial	Park	01/29 1999	Landove		
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	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C	ua to (or as a co	nsaquance of)	*					
a discount	thet initieted avants rasulting in death) Last	d	ua to (or as a cor	nsequance of)					i	
	Pert II. Other significant conditions co	ontributing to death but	not rasulting in the	ha undariving	causa di	van in Part I.	23b. Dlo	I tobacco use co	ntribute to the	e cause of dea
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death

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hysician /Medicai		me <i>(First, Middl</i> e, <i>La</i> AYE JEFFR						2. Date of D Month JANUAF		9 Š ^{aar}	3. Time of Death 9:43am
xaminer		(If not institution, giv DOAKS NU					4b. City, Town, CLINTO	or Location of Dea	P.G.		Y.
neral ector	5. Social Security 579-34-	0364	Sax 7. I□M 2X F	Aga (In yrs. I	ast birthday) Yrs.	If Undar 1 Ya Months Da		Hrs. 8 Data of B Month, D NOV 4	irth 1926	9. Births Cour ALAB	olaca (State or Forei ntry) AMA
*	Usual Residence	of Decedent 10b. County		10c City	, Town or Loc	ation					10d. Inside City Lim
or 288-f show	MD	PRINCE (EORGES		STRICT		rs				XX Yas 2 1
rect	10e. Street and N		JOROLD		DIKIGI	10f. Zip Cod	_		10g. Citizen of	What Cou	ntry?
E D	6302	GATEWAY BI	LVD				20747		UNITE	ED ST	ATES
injoining or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		rried 2 Married	12. Was Decede Armed Force 1 ☐ Yes Xi If Yes, Giva Year or Date	S? X No			of Hispanic Origin? Juban, Mexican, Po No Specify:	(Specify Yes or Nuerto Rican, etc.)		ce - Americ ck, White, by: BL	
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To Be (17. Fathar's Name UNKNOWN	(First, Middle, Last)					Name (First, Middle IITA COLE		ne)	
E I	19a. Informant's I	Name/Relationship (Type, Print)		19b. Mailing	Address (Str	eet and Number of	Rural Route Num	ber, City or Town	, State, Zip	Code)
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ony in	21. Signatura of F	uperal Servica Licer	1 Pope	2	22.	ALI		POPE F			20747
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ian	arrow, or tro	art landro. Electorny				s .)			Onset and Death
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should	. 0		/					24a. Wa peri	s an autopsy ormed?	av	are autopsy findings vailabla prior to empletion of causa daath?
director, page 2								1□	Yes 20 No	1[□Yes 250No
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t the	3 ☐ Suicida 4 ☐ Homicide	6 Could not b determined	Zoe. Flace of	Injury - At ho etc. (Specify	me, farm, stre	et, factory, offi	ce		(Street and Numi own, Stata)	ber or Rure	al Route Number,
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edical Cer	(Check only one)	2 Miodicai Exail				00.11	nana aumbas		and Data stand	of Aldonth	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Theresa A. Jones January 8, 1999 10:00 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** 8600 Mike Shapiro Drive #214 Clinton. Prince George's If Under 1 Year 8. Dete of Birth June 14, 1932 Birthplace (State or Foreign Mar y Tand 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours Min 1 M 2 XF 66 Yrs. Director 214-36-4590 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. inside City Limite 10b. County - Phow r than "naturel", or items 23s or 28s-f ehore Wedical Examiner must be notified at 1XXYes 2 □ No Prince George's Mary land Clinton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 U.S.A. 8600 Mike Shapiro Drive #214 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2)(No Specify: py 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th grade Cook Restaurant permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked oths any injury or other treumatic event, pages. 18. Mother's Nama (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) Be Thomas R. Jackson, Sr. Mary Catherine Ennis 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mr. Purnell M. Jones (Husband) 8600 Mike Shapiro Drive #214 Clinton, Maryland 20735 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burlal 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetlon 5 Other (Specify) Resurrection Cemetery 1/13/99 CLinton, Maryland 22. Name and Address of Facility
ROllins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, and only one cause on aech line. 23e. Pert1. Enter the observed to the Approximeta Intervel Between Onset and Death **Physician** CARCINOMA OF THE EYE /Medical Immediate Cause (Final dieeese or condition resulting in daeth) Examiner Examiner physician and s the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated evants resulting in deeth) Lest Due to (or as e consaquence of): The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the causs of death? signed by the CHRONIC OBSTRUCTIVE LUNG DISEASE 1 Y00 2□ No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? SEIZURE DISORDER completion of cause of deeth? page 2 1 Yes 2 XNo 1 Yes 2KXNo Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was cese referred to medical exeminer? 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Deeth 28e. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1XXNeturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcide 8 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At homa, farm, streat, factory, office building, etc. (Specify) in by 4 - Homicida 24 hours af Euneral Di letely filled in 1 Cartifying Phyeician: To tha best of my knowledga, daath occurred at the time, date end place, and due to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at tha time, data and piece, and due to the cause(s) end manner stated. Medical 29a. Cartifier

To the Hosp within 24 hot To the Fune completely fil

Louis V. Kaufman, M.D. 31. Dete filed (Month, Day, Year)

JAN 1 9 1999

30. Name end eddress of person, the completed cause of deeth (Item 23e) (Type, Print)

29b. Signature and title of certifier

(Check only one)



29c. License number

29d. Dete signed (Month, Day, Year)

Registrar

Some A francis

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	1. Decedenf's Nam	T G770 4-1- na (First, Middla, La			0	ertificate	OI L	Joann	2. Date of Do	Reg. No.	Yaar		na of Death
an cal	Cather	rine	F.	Jo	hnsto	on			Januar		1999		00 am
r	4a Facility Nama (If not institution, giv	e street and number)				4	b. City, Town, or L	ocation of Dea	th 4c. Co	unty of Dec	ath	
		Jnderwood						Univers				George	
	5 Social Security N 577 277-09-4 Usual Rasidanca o	128	Sax 7. Ag	ga (In yrs. 89	last birthdi Yrs	Months [Days	If Undar 24 Hrs. Hours Min.	(Month, D	orth ay, Year) 6, 1909			arolina
	10a. Stata	10b. County		10c. Cit	y, Town or	r Location							la City Limits
Directo		Prince G	eorge's	Uni	vers	ity Park							165 245140
ś	10e. Street and Nu					10f. Zip C				10g. Citizen		Country?	
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1			ona causa on aach l	ine.	ii. Do not	antar tha mode		g, such as cardiac	enue, Hy corraspiratory	arrast,			Between
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Completed by Physician/Medical	disease or conditi- resulting in death) Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated avent resulting in death) Part II. Other signi 25. Was case rafe axaminar? 1 Yas 20 27. Menner of Dea 1 Whaturel 2 Accident 3 Suicide 4 Homicide	onditions, mmadiate anying rinjury is Last lifecant conditions of the conditions of	b	Dua to (co Dua to (co	or as a confor as a confor as a conformation of the conformation o	esequence of): asequence of):	usa givo	en In Part I. 26. Place of Darar: 4 Nursing Hyat k? Yas 2 No	23b. Did 24a. We per ath (Chack only loma 5 106 28d. Dascribe 28f. Location City or T	d tobacco ue Yes 2 Is an autopsy formed? Yas 2 Is an autopsy formed? (Straat and Nown, Stata) e cause(s) an a, data and pl	24t No 3 Other (Specured	interval Onset Onset Interval Onset Interval Onset Interval Int	use of death? 4 Unknown psy findings prior fo n of causa 2 No
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DHMH 16 Rev 6/95

JANES 2 1999 From M. Janes

Physician

/Medical

Examiner

Director

Funeral

Director

b

1. Decedent's Name (First, Middle, Last)

4e. Fecility Name (If not institution, give street end number)

10b County

5905 Berwyn Road

1 Never Merried 2 Married

Doctor's Community Hospital

Mary

5. Social Security Number

Usual Residence of Decedent

211-10-7226

Maryland

10e. Street and Number

10a. State

Margaret Kovalchik

1 M 2 X F

Prince George's

7. Age (In yrs. last birthday)

82

12. Wes Decedent Ever in U,S. Armed Forces?

Yrs.

Berwyn Heights

10c. City. Town or Location

Completed by Funeral Yes 2 No Yes, Give Year or Dates: 3 Nidowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Seamstress Self Employed 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 12 should be to h and Mental H Is marked off John Gmitter Susan Dzurenda 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) of Health a vet. If from 27 is view of the Robert S. Kovalchik - Son 5905 Berwyn Road, Berwyn Heights, Maryland 20740 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State Dete Pages 1 ☑ Buriei 2 ☐ Cremation 3 ☐ Removel from State Department Important: If 4 ☐ Donation 5 ☐ Other (Specify) 01/22/99 Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD Enry Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, or heart failure. List only one ceuse on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical myocardial infarction Examiner Examiner Cardio bascular disease interioseles otic The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ Completed 24e. Wes en autopsy performed certificata has 1 ☐ Yes 2 No Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Affer 1 Naturei 5 Pending investigation 1 Yes 2 No 2 Accident after death Director: the 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide ò

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Year

Days

20740

1 ☐ Yes 2 No Specify:

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end manner stated.

29c. License number

YOON, M.D. 7307 BALTIMORE AVE. #111. COLLEGE PAK.

2. Dete of Death

JANUAR)

Jan. 6, 1917

4c. County of Deeth

10g. Citizen of What Country?

U.S.A.

Specify.

Prince George's

14. Rece - American Indian, Bleck, White, etc.

White

Month

4b. City, Town, or Location of Death

Lanham

if Under 24 Hrs.

Hours

Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.)

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 X Yes 2 No

20781

24b. Were autopsy findings available prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year)

Pennsylvania

3. Time of Deeth

6138 PM

24 hours Hospital

To the Hosp within 24 ho To the Fune completely f

Medical

State

Registrar

29a. Certifier

(Check only one)

29b. Signeture end title of certifier

YEAR-KOON H.
31. Dete filed (Month, Day, Year)

partamy.

JAN 2 0 1999

30. Name and address of parson who completed cause of deeth (Item 23e) (Type, Print)

32 Registrer's Signeture

10 P 4 1960

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 0315 21, 1999 January Edward John Lynch /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □XM 2 □ F 88 October 22, 1910 Maryland Director 213-05-1847 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show POYes 2 No Director 28a-t Maryland Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21921 United States Name 23a 42 Hollingsworth Manor Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 3 Yes 2 No 1927-If Yes, Give 1930 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried White Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Year or Detes: 3 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglece. Elementery/Secondary (0-12) College (1-4or 5+) Carpenter Construction Pages 1 and 2 should be filed nent of Health and Mental Hygis net; If Item 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Mary E. Powell Edward A. Lynch 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Lynch/ Wife 42 Hollingsworth Manor, Elkton, Maryland 21921 tant: If lisen 27 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete January 25, 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify) Elkton, Maryland Elkton Cemetery 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Funerals, P.A. Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examine Examine attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a conseque Box 68760 corpu Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To of this 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide in 24 hour. 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) within 2 vito the F 29b. Signeture end little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 JANUARY 21, 1999 032275 5 Copies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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7

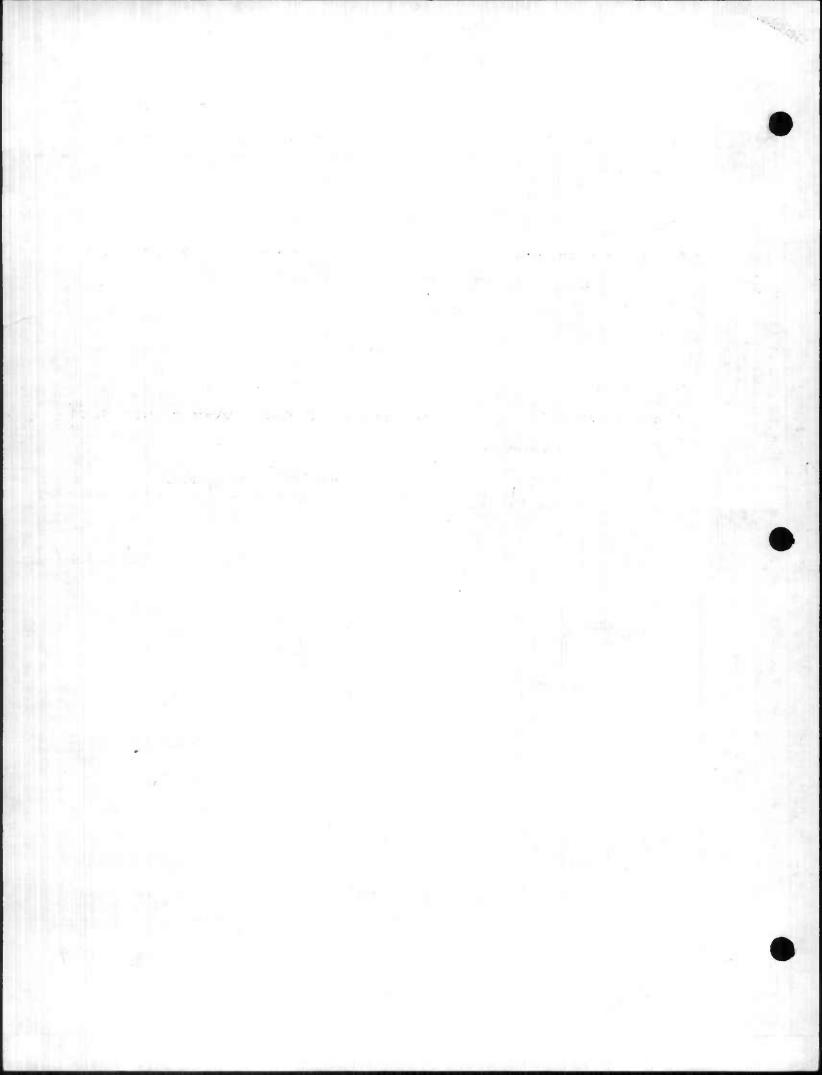
Edward Joh

ynch,

HVA

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675 W 32. Registrar's Signarure



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 0/6 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 159 AM TRUVARY GERALDINE LAWRENCE 1999 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTORS COMMUNITY HOSPITAL PRINCE GEORGES LANHAM If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Yrs. 578-70-3547 May 18, Director 1952 Wash., D.C. 46 Usual Residence of Decedent 10a. State r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Maryland Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20743 United States 340 Possum Court 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT PRIVATE permit. Pages 1 and 2 should be filed Department of Heelth and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) ERLINE WILLIAMS 9 ETHEL ALEXANDER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 340 POSSUM COURT, Capitol Hts, Md. 20743 ALONZO F. LAWRENCE / HUSBAND 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/16/99 ALEXANDRIA, VIRGINIA METROPOLITAN CREMATORY 22. Name end Address of Facility
ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SE DC 20020 ZULI FENNSYLVANÍA AVENUE, SE comparts the mode of dying, such as cardiac or respiratory arrest, on each line. 23e. Part1. Enter tife di lea shock, or heart failure Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Acute Pancrea 48 hrs Examiner Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): 88 ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 000 3 ☐ Probably 4 ☐ Unknown failure hypotension signed b þ 24b. Were autopsy findings available prior to Completed 24e. Wes an eutopsy coagulo pathry 20 to acute hepatic failure, peed completion of cause of death? metabolic acidosis 2 0 No resp. failure 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No sing To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral is 27. Manner of Death

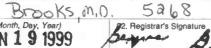
1 A Natural

2 Accident 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28d. Describe how Injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the ceuse(s) end menner stated. edicai 29a, Certifier

State Registrar 31. Date filed (Month, Dey, Year)

JAN 1 9 1999

29b. Signature and title of certifier



Brooks

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number

Dawes Are, Alexandria VA

29d. Date signed (Month, Day, Year)

AWKENCE, GEKALDNE

Box 68760.

P.O.

Records,

of Vital

Division

The law

te 6. 11

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Day **Physician** Bernice Arrington Lloyd 1999 January 13 7:15AM /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Manor Care -Largo Largo Prince George's If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplace (Steta or Foreign Country) **Funeral** 1 M 2 XF Months Yrs 577-42-5327 69 **Director** March 8, 1929 South Carolina Usuai Residence of Decedent with the Maryland 10d. Inside City Limits ehow. 10e. Stete 10b. County 10c. City, Town or Location r than "naturel", or items 23s or 28s-1 ehover the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Prince George's Suitland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4662 Lamar Ave. 20746-1124 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indian. 11. Merital Stetus Bleck, Write elcan permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or item any injury or other traumatic event, the Marical Exercises Back. 1 ☐ Yes 2 X No If Yes, Give Yaar or Datas: 1 Never Merried 2K Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: American þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) $10 \, \mathrm{th}$ College (1-4or 5+) Housewife Private 18. Mothar's Nama (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pack Thompson Eva T. Sims 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Raiationship (Type, Print) 9539 Ridgeview Dr., Columbia, MD Herbert J. Arrington - Son 20b. Pleca of Disposition (Nema of cemetery, crematory or other plece) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Buriel 2 □ Cremetlon 3 □ Removel from Stete 4 □ Donation 5 □ Other (Specify) Arlington National Cem. 1/22/99 Arlington, VA 21 Signature of Funeral Servica Licanspe 22. Nama and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 wow Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, or heef feiture. List only one cause on each line. Approximete Intervei Between Onset and Deeth **Physician** Immediate Tausa (Final disease or condition resulting in deeth) /Medical · Brain Tumor Right Tempero-Panietal Terminal 1 year Examiner Examiner that the deeth certificate be executed physician end the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or injury that initiated evants Dua to (or as a consequence of) Box 68760. Physician/Medical that initiated evants resulting in death) Last Due to (or es e consequence of) 950 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Pert I. P.0. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings aveileble prior to completion of cause of daeth? 24a. Wes an eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No certificate Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certific. 25. Was case raferred to medical exeminer?
1 □ Yes 2 □ No Be 26. Placa of Daeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 27. Mapnar of Daath 28a. Data of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida 152 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end dua to the causa(s) and manner es stated.
2 Medical Examiner: On the bests of exeminetion end/or investigetion, in my opinion, deeth occurred et the tima, dete end piece, and dua to the cause(s) end menner steted. 29e. Certifier Medical (Check only one) To the I within 2 29b. Signature and titla of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 20108 Kakushanong, MD January 15, 1999 30. Nama and addrass of person who completed cause of deeth (Item 23e) (Type, Print)
14300 GALLANT FOX LANE #222, BOWIE MD. 20715

Registrar

31. Deta tiled (Month, Day, Year)
JAN 1 9 1999

62. Registrer's Signature

See and See and See and See

THE LEGISLAND

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month LESTER S. LANE JAN. 16, 1999 /Medical 9:10 PM 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY CO. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Aga (Iri yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1**X** M 2□ F 90 560-03-1552 Yrs **Director** JUNE 28,1908-MARYLAND Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits ns 23a or 28a-f show MD. MONTGOMERY ROCKVILLE Director 1) Yes 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 USA Funerai 12. Was Dacedent Ever in U,S.
Armed Forces?
1 [X]Yas 2 □ No
If Yes, Give
Year or Detes: WW 11 Was Decedent of Hispenic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 11. Merital Stetus traumatic event, the Medical Examiner filed within 72 hours after 1 Nevar Married 2 Married 21215-0020 ò by 1 ☐ Yes 2 → No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education
(No only highest grade completed) Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade Hygiena. Eiementery/Secondery (0-12) College (1-4or 5+) Sales Not Available Baltimore, Maryland 17. Fathar's Nama (First, Middla, Lest) 18. Mother's Name (First, Middle, Malden Sumeme) . Pages 1 and 2 should be fill ment of Haalth end Mantal Hyant: If tem 27 is marked oth lury or other traumatic event Be HARRY LANE ELLA SPICKNALL 0 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) KATHERINE MARINO-DAUGHTER 120 Chatham Woods Dr.; Carey, North Carolina 27511 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1X Burial 2 Cremetion 3 Ramovei from State permit. Page Department of Important: If any injury or once. FT.LINCOLN CEMETERY 1/20/99-BRENTWOOD, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name end Addrass of Fecility HYSONG CO., INC. ·M ins. thet caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, euse on each line. Approximate interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final disaesa or condition resulting in deeth) Examiner Due to (or es e consequence of) Dussure The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, attending physician Physician/Medical the Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Usinang l Records, þ 24b. Were autopsy findings aveilebla prior to completion of causa of death? Completed 24e. Wes en eutopsy performed? certificate Division of Vital rlenos des Attanding Physician: Be 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this Certification: 27. Menner of Death 28b. Time of 28e. Dete of injury (Month, Dev Year) 28c. injury at Work? 28d. Describe how injury occurred Aftar 1 Neturel 2 Accident 5 Pending Investigation death. 1 Yes 2 No Hospital or Attandi 24 hours efter death. Funeral Director: A etaly filled in by the fi 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours e Medical 29e. Certifier Tertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted.

| Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete and pleca, end due to the cause(s) end menner steted. 29b. Signeture end title of 29c. Licensa number 29d. Data signed (Month, Day, Year) 036618 M. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTOPHER SCHEMM- 9701- VEIRS DR., ROCKVILLE, MD. 3. Registrer's Signatura 31. Data filed (Month, Day, Year) State JAN 2 0 1999 Registrar

AREA BY THE SPECIAL SPECIAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2 Date of Death 3. Time of Death **Physician** ELIZA W . LEWIS 1999 5 Jan. DM /Medicai 4c. County of Death 4a. Fecility Nema (If not institution, giva street and numbar) 4b. City, Town, or Location of Death **Examiner** Joseph Richey Hospice Baltimore If Under 1 Yaar January 5, 1909

9. Birthpiaca (Stata or Foreign Country)

York County, S.C. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Birthpiaca (Stata or Foreign Country) 1 □ M 20X F Months Days Hours Min 579-26-8242 90 Yrs. Director Usuai Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits nd Mental Hygiene. marked other than "natural", or Items 23e or 28e-f show umatic event, the Medical Evamine must be notified at Maryland Prince George's 1 Yes 2 □ No Director Greenbelt 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6815 Damsel Court 20770 U.S.A. 12. Was Dacedent Ever in U.S. Armed Forces? 11 Maritai Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puarto Ricen, etc.) 14. Race - American Indian, Bieck, White, etc. Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black by 3 X Widowed 4 □ Divorced Year or Dates: Completed 16e. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 8th Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Sumame) Be 1 end 2 should be Heaith and Mental (Unknown) Frances White Lo 19e. informant's Neme/Reietlonship (Typa, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) Important: If item 27 is any injury or other trau John L. White/Nephew 6815 Damsel Court, Greenbelt, Maryland 20770 20e. Method of Disposition 20b. Piece of Disposition (Nama of cemetary, crametory or other placa) 20c. Location - City or Town, State tot 1 ☑ Buriai 2 ☐ Crametion 3 ☐ Removei from Stete Lincoln Memorial Cemetery 1998 Suitland, Maryland 4 Donetion 5 Other (Specify) 21. Signature of Funerei Service Licensee J. B. JENKINS FUNERAL HOME Per Name 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter tha moda of dying, such as cerdiac or respiretory arrast, shock, or haert failure. List only ona ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Ceusa (Finel disaase or condition resulting in daath) /Medical CARCINO MA COLON WITH METASTASES 245745 **Examiner** Due to (or es a consequence of) Examiner requires that the death certificete be executed Sequantially list conditions, if eny, laeding to Immediate ceuse. Enter Undarlying Ceuse (Disease or injury that initieted events resulting in death) Lest burial-trar Due to (or as e consequence of) 68760 physician Physician/Medicai the Due to (or es a consequance of): Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobecco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 → Whknown been signed t should be det Records, þ 24b. Wara autopsy findings aveilable prior to Completed 24e. Was an autopsy completion of cause of daath? The law page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No Vital Physician: 25. Wes cese referred to medicel examinar? Be 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Sthar (Specify) HOSPICE P 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Division of this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred After Attending 1 Naturel 5 Pending investigation Injury 1 ☐ Yas 2 ☐ No To the Hospital or Attends within 24 hours after death To the Funeral Director: A completely filled in by the fi death 2 Accident 6 Could not be 3 ☐ Suicida 28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Spacify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata) detarmined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Cartifiar Medical (Check only 29b. Prinally a end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Lewis

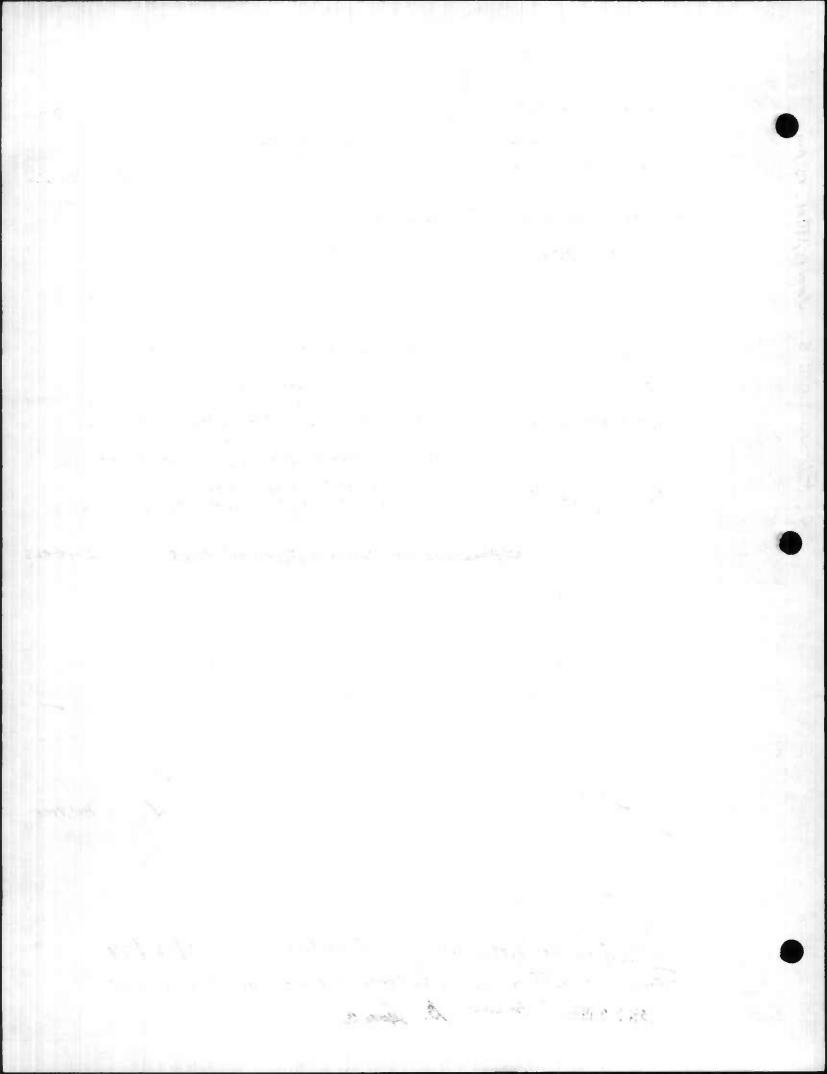
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31. Dete filed (Month, Day, Yaar) State JAN 2 0 1999 Registrar

JOHN & MACTIBBON 14 WREAD ST BACOMORE MD 21201 32. Registrar's Signeture

hD.

and eddress of parson who complated ceuse of deeth (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

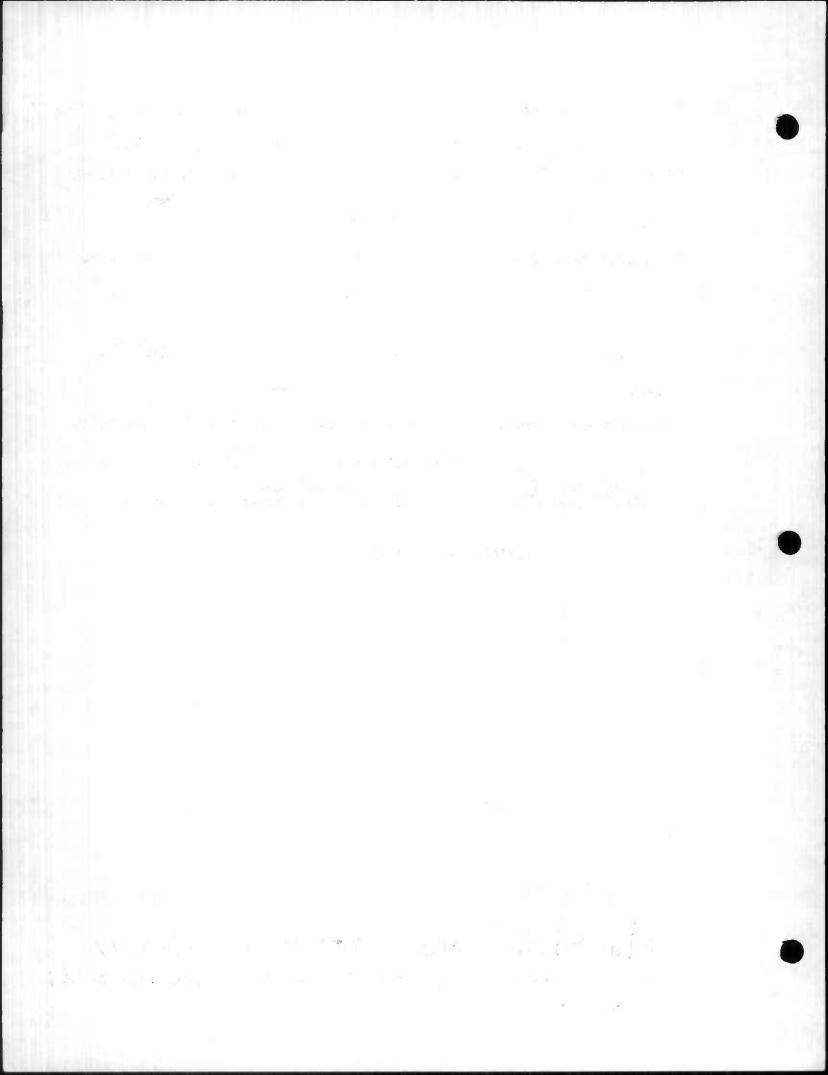
	1. Decedent's Name (Fi	irst, Middle. Las	et)				Death	2. Date of Dea	leg. No.	3. Tim	ne of Death	
ician	Dorothy V:	A STREET	Lind	sav				Month	Day	Year		
cal	4a Facility Name (# not						4b. City, Town, or	January	4c. County		:10 am	
er	Prince Geor				r		Cheverly			e George	S	
	5. Social Security Numb				s. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Dete of Birth				
	214-34-6885 Usual Residence of Dec)	□M 2\\ F	84	Yrs.	Months Days	Hours Min.	8. Dete of Birth (Month, Day Aug. 24	, Year) 1914	9. Birthplece (St. Country) Washingt	on, DC	
		b. County		10c. 0	ity, Town or Lo	cation					le City Limits	
Funeral Director	Maryland Pr	rince G	eorge's	La	ndover					162	Yes 2□No	
5	10e. Street and Number	r				10f. Zip Code			log. Citizen of W	hat Country?		
	6212 Osbori	ne Road				20785		1	.S.A.			
2	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dece Armed For 1 Pes If Yes, Giv Year or De	ces? 2 ⊠ No		Ves Decedent of I I Yes, specify Cub ☐ Yes 2 No	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race Bleck Specify:	e - American India k, White, etc. : White	n,	
İ	15. (Specify o	Decedent's Ed	ucation de completed)		16a. Deced	lent's Usuel Occup	pation during most of wo	rkina	16b. Kind of Bu	siness/Industry	-	
no combined on	Elementary/Secondar	-	College (1	4or 5+)			during most of word)		0 77			
1	10	Alidella 1 and			House	wire	10 Mash - 4- 4-	ma (First Asidd)	Own Hon			
	17. Father's Name (Firs							me (First, Middle,	walden Sumami	Θ)		
2	John Osbori	2000			4		Clara B		0			
n 27 le	19a. Informant's Name/									m, State, Zip Code)		
	William G.		y - Spor		Place of Dispos		koad, Lai			nd 20785		
	20a. Method of Disposit 1 ☐ Burial 2 ☐ Cr		Removal from S		cemetery, cren	sition (Neme or netory or other pla		Dete		City or Town, Stat		
1	4 □ Donation 5 □	Other (Specify)			coln Ceme	1/20/99	9 Brentwood, Marylan				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A.											
	Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville										781	
	23a. Part1. Enter the di shock, or heart fei	isease, or comp	lications that ca	used the de						Approx	imate Between	
	or Hours To	Land Conty	0.1000 (#1 00							Onset	and Death	
	Immediate Cause (Fina disease or condition	al	Asyst	nle						10 M	inutes	
	resulting in death)		a. Hoyse		(or as a conseq	uence of):				10 11.	Linutes	
Mical Evalling			. Acute		ratory					7 Hou	ırs	
	Sequentially list condition	ions,	b		(or as a conseq					1, 1100		
	Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injur	diate	Coma							6 Hou	ırs	
	that initiated events		c.	Due to	or as a consequ	uence of):				0 1100	* = 0	
	resulting in death) Last		Acute		nary Em			12 H			nire	
			d. Ziedee	T GTIIIO	LALY DI	DOTTON			12 Hours			
-	Part II. Other significan	t conditions co	ntributing to de	ath but not re	sulting in the ur	nderlying cause of	ven in Part I	23b Did to	obacco usa con	ntributa fo the car	use of death?	
									as 2 No	3 Probably		
	Hypertensiv	ve Hear	t Disea	se, Co	ronary	Artery D	isease,	,	-2 = MD 140	- La . Touanny	- C O'IMIONII	
	Diabetes Me	ellitus						24a. Wes e		24b. Were auto available p	rior to	
									completion of death?	UI CaUSO		
								1 ☐ Yes 2 ☒ No 1 ☐ Yes				
								1 🗆 Y	es 2⊠ No			
	25. Was case referred to examiner?	-						1 □ Y		1 Yes	2□ No	
	examiner? 1 ☐ Yes 2 ☒ No	-	1 41		☐ ER/Outpatien	1 JLI DON	her: 4 Nursing H	ath (Check only or	ence 6 Othe	er (Specify)	2 No	
	examiner? 1 Yes 2 No 27. Manner of Death		28a. Date o		ER/Outpatien	t 3 DOA Oti	her: 4 Nursing H	ath (Check only or	ence 6 Othe	er (Specify)	2□ No	
	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident	Pending investigation	28a. Date o	f Injury	28b. Time of	28c. Inju	her: 4 Nursing H	ath (Check only or	ence 6 Othe	er (Specify)	2□ No	
	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident	Pending	28a. Date o (Monti	Injury , Day Year)	28b. Time of Injury	28c. Inju	her: 4 Nursing H ny at rk?	ath (Check only or dome 5 Resid	ence 6 Other	er (Specify)		
	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier 1N (Check only 2	Pending investigation Could not be determined	28a. Date o (Montil 28e. Place buildin	f Injury t, Day Year) of Injury - At g, etc. (Spec best of my kr sis of examir	28b. Time of Injury home, ferm, stra	28c. Inju Wo M 1 C	her: 4 Nursing H ny at rk?	ath (Check only or flower 5 Resid 28d. Describe h	ence 6 Other ow injury occurreted and Number on, State)	er (Specify) ed er or Rural Route	Number,	
	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	Pending investigation Could not be determined Certifying Phy Medical Exam	28a. Date o (Month	f Injury t, Day Year) of Injury - At g, etc. (Spec best of my kr sis of examir	28b. Time of Injury home, ferm, stra	28c. Inju Wo M 1 ==================================	her: 4 Nursing F ry at rk? IYes 2 No me, date and place ppinion, death occu	ath (Check only or dome 5 Resid 28d. Describe h	ence 6 Other ow injury occurred and Number of State) ause(s) and melate and place, a	er (Specify) ed er or Rural Route nner as stated. and due to the cau	Number,	
	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier 1N (Check only 2	Pending investigation Could not be determined Certifying Phy Medical Exam	28a. Date o (Montil 28e. Place buildin	f Injury t, Day Year) of Injury - At g, etc. (Spec best of my kr sis of examir	28b. Time of Injury home, ferm, stre	28c. Inju Wo M 1 C Seet, factory, office occurred at the tiestigation, in my c 29c. Licent	her: 4 Nursing H ny at nk? I Yes 2 No me, date and place opinion, death occuse number	ath (Check only or forme 5 Resid 28d. Describe h 28f. Location (S City or Tow e, and due to the curred at the time, c	ence 6 Other ow injury occurrence and Number of Number o	er (Specify) ed er or Rural Route enner as stated. and due to the cau	Number,	
	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title	Pending investigation Could not be determined Certifying Phy Medical Exam	28a. Date o (Mont) 28a. Place buildin 28c. Place buildin 28c. Place and mann	I Injury I, Day Year) of Injury - At g, etc. (Spec- pest of my kr sis of examir er steled.	28b. Time of Injury home, ferm, streethy) bowledge, death action and/or inv	28c. Inju Wo M 1 Coest, factory, office cocurred at the tirestigation, in my of 29c. Licens D2 2 5	her: 4 Nursing H ny at nk? I Yes 2 No me, date and place opinion, death occuse number	ath (Check only or forme 5 Resid 28d. Describe h 28f. Location (S City or Tow e, and due to the curred at the time, c	ence 6 Other ow injury occurrence and Number of Number o	er (Specify) ed er or Rural Route nner as stated. and due to the cau	Number,	
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Medical Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title	Pending investigation Could not be determined Certifying Phy I Medical Exam	28a. Date o (Montil 28a. Place buildin 28a. Place buildin 28a. Place buildin 28a. Place buildin 28a. Place buildin 28a. Place buildin 28a. Place buildin 28a. Place buildin 28a. Place buildin 28a. Place building 28a. Place buil	I Injury I, Day Year) of Injury - At g, etc. (Spec pest of my kr sis of examir er steled.	28b. Time of Injury home, ferm, stre ifly) www.dedge, death action and/or inv M. D. pm 23a) (Type, I h Avenu	28c. Inju Wo M 1 Coest, factory, office coccurred at the tirestigation, in my of 29c. Licens D2 2 5	her: 4 Nursing H ny at nk? I Yes 2 No me, date and place opinion, death occuse number	ath (Check only or dome 5 Resid 28d. Describe h 28f. Location (5 City or Towns, and due to the curred at the time, c	ence 6 Other ow injury occurred and Number of State) ause(s) and mediate and place, and place, and place of State of St	er (Specify) ed er or Rural Route en or as stated. and due to the cau d (Month, Day, Ye	Number,	

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

hysicia		Decedant's Nama (First, Midd	ila, Last)					2. Data of Daa	th Day	Yaar	3. Tima of Death
/Medica			MOWBRAY					January	24	1999	1957
Examine	er	4a. Facility Nama (If not institution	on, giva straat and nun	n <i>ber)</i>			4b. City, Town, or L	ocation of Dagith	4c. County	of Death	
		Union Hospital				Williams of Vene	E1kto			Cecil	
ineral rector		5. Social Sacurity Number 214-14-9336 Usual Residence of Decedant	6. Sax 1⊠ M 2□ F	7. Aga (In yrs. 78	Yrs.	Months Days	Hours Min.	8. Data of Birth (Month, Day December	, Year) 2, 1920	9. Birthpiac Country Virgi	a (Stata or Fora Inia
thow tel		10a. Stata 10b. County	у	10c. Ci	ty, Town or Loc	ation				10d	. Insida City Lim
28a-f show	cto	Maryland Ceci	1		North	East					1 ☐ Yas 2 📆 I
De n	Director	10e. Street and Number				10f. Zip Coda		1	log. Citizan of \	What Country	7
23	rai	546 Bethel Chu				21901				ed Sta	
item 27 is marked other than "natural", or terms 23s or 28s-1 shor other traumstic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Navar Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	Armad For rried 1 ☐ Yas If Yas, Giv	2 No	if	/as Dacadant of F Yas, specify Cub ☐ Yas 2⊠ No	dispanto Ortgin? (Sp an, Maxican, Puarto Specify:	pecify Yas or No- Pican, atc.)	14. Rac Blac Specify	ea - Amarican ck, Whita, atc Whit).
natural edical Exp	etec	15. Deceder	nt's Education ast grada completad)		16a. Decade	ent's Usual Occup	pation during most of work	cina	16b. Kind of B	usinass/Indus	stry
the Me	Completed by	Elementary/Secondary (0-12)		-40r 5+)	17.0	ONOT usa retire nanic	during most of work d)	9		mobile ership	
vent,	Be	17. Fathar's Nama (First, Middla,	, Last)				18. Mothar's Nam	e (First, Middla,		-	
rikad	2	unknown					unknow	n			
aume a		19a. Informant's Nama/Ralation	ship (Type, Print)		19b. Mailing	Addrass (Street	and Number or Rui	ral Routa Numbe	r, City or Town,	Steta, Zip Co	oda)
m 27 her tr		Thelma Mowbray	/ Spouse			The second second second second	urch Road	T .			901
or ite		20a. Mathod of Disposition 1⊠ Burial 2 ☐ Cramation	3 Ramoval from S		Piace of Dispos cematery, cram	ition (Nama of atory or othar pla	ce)	Jan. 28	20c. Location -	City or Town	n, Stata
Jury	-	4 Donation 5 Othar (5	3 /	Ro	T	Cemete	-	1999	Calvert	, Mary	land
Important: If item 27 any injury or other to once.		21. Signature of Funeral Service	(Lifenson		Cro		ss of Facility eral Home Main Stre		h East	MD	21901
niner	ner	resulting In death)	a		ANCE						
100	C		b	Dua to (d	or as a c <i>on</i> saqu	ance of):					
	Examiner	Sequantially list conditions, if any, laeding to immediata cause. Entar Underlying	5 b		or as a consaqu						
physicials the bur	edicai	Sequantially list conditions, if any, laeding to immediata cause. Entar Underlying Causa (Diseese or Injury that Initiatad avents resulting in daath) Lest	b	Dua to (d		ranca of):					
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ins certificate has been signed by the eltertoing physical director, page 2 should be deteched for use as the but To Be Commissed by Dhysical and Maddical	To be Completed by Physician/Medical	Part II. Other significant condition 25. Was case referred to madice axaminar? 1 □ Yes 2 □ No 27. Manner of Deeth 1 □ Natural 5 □ Pandli	Hospital: 1 1 28a. Date o	Dua to (o	or as a consequ	anca of): anca of): darlying causa give 3 □ DOA Oth 28c. Injur Wor	26. Placa of Deat ear: 4 ☐ Nursing Ho	1 Y	in autopsy med? as 2 No	3 Probab 24b. Wara availa comp of dea 1 Y	autopsy finding able prior to lation of causa ath?
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ctor: After this certificate has been signed by the eltertoing physical y tha funeral director, page 2 should be deteched for use as the but floation. To Be Commissed by Dhyselelan Madical	Certification: 10 Be Completed by Physician/Medical	Part II. Other significant conditions a saminar? 1 Yes 2 No 27. Manner of Deeth 1 Natural 5 Pandli Invasti 2 Accidant 1 Suicida 6 Could detarm 29a. Cartifiar 1 Cartifyir	Hospital: 1 28a. Date o (Month inped) 28a. Place o 28a. Place	Dua to (o Dua to (o Dua to (o ath but not ras finjury, h, Day Yaar) of Injury - At h. g, atc. (Specif, best of my kno	or as a consequence as	anca of): anca of): darlying causa give 28c. Injur Wor M 1 1 at, factory, office	26. Placa of Deal ar: 4 □ Nursing Ho y at k? Yas 2 □ No	1 Your 24a. Was a perform 1 You th (Chack only or one 5 Pasidi 28d. Dascribe his 28f. Location (St. City or Town end dua to that c	in autopsy med? as 2 No na) ance 6 Oth ow injury occur treet and Numb n, Stata) ausa(s) and ma	3 Probab 24b. Wara availa comp of dea 1 Y per (Specify) red per or Rural R	autopsy finding ble prior to lation of causa ath? 'as 2 No
ins certificate has been signed by the eltertoing physical director, page 2 should be deteched for use as the but To Be Commissed by Dhysical and Maddical	ledical Certification: 10 Be Completed by Physician/Medical	25. Was casa rafarrad to madica axaminar? 1 Yes 2 No 27. Manner of Deeth 1 Natural Invasti 3 Suicida 6 Could detarn 29a. Cartiflar (Check only 2 Medical)	Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Dua to (o Dua to (o Dua to (o ath but not ras finjury, h, Day Yaar) of Injury - At h. g, atc. (Specif, best of my kno	or as a consequence as	anca of): anca of): darlying causa give 3 DOA Oth 28c. Injur Wor M 1 at, factory, office coccurred at tha tir stigation, in my o	26. Placa of Deat ear: 4 □ Nursing Ho y at k? Yas 2 □ No ne, dete and place, plnion, deeth occur	1 Yes 24a. Was a perform 1 Yes 16h (Chack only or ome 5 Rasida 28d. Dascribe his 28f. Location (St. City or Town end dua to that cered at the time, decreed	in autopsy med? as 2 No na) ance 6 Oth ow injury occur treet and Numb n, Stata) ausa(s) and ma	24b. Wara availa comp of dea 1 Y	autopsy findinible prior to lation of causa ath? as 2 No



0020	g physician
1215-(or attendin
AND 2	e hospital
BALTIMORE, MARYLAND 21215-0020	ained by th
RE, M	may be ret
TIMO	h. Page 6
BAL	s after death
0	24 hours
	-
09,	d with
68760	executed with
BOX 68760	icate be executed with
P.O. BOX 68760	th certificate be executed with
ORDS, P.O. BOX 68760	that the death certificate be executed within 24 hours after death. Page 6 may be reta
RECORDS, P.O. BOX 68760	w requires that the death certificate be executed with
ITAL RECORDS, P.O. BOX 68760	. The law requires that the death certificate be executed with
OF VITAL RECORDS, P.O. BOX 68760	HYSICIAN: The law requires that t
DIVISION OF VITAL RECORDS, P.O. BOX 68760	OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

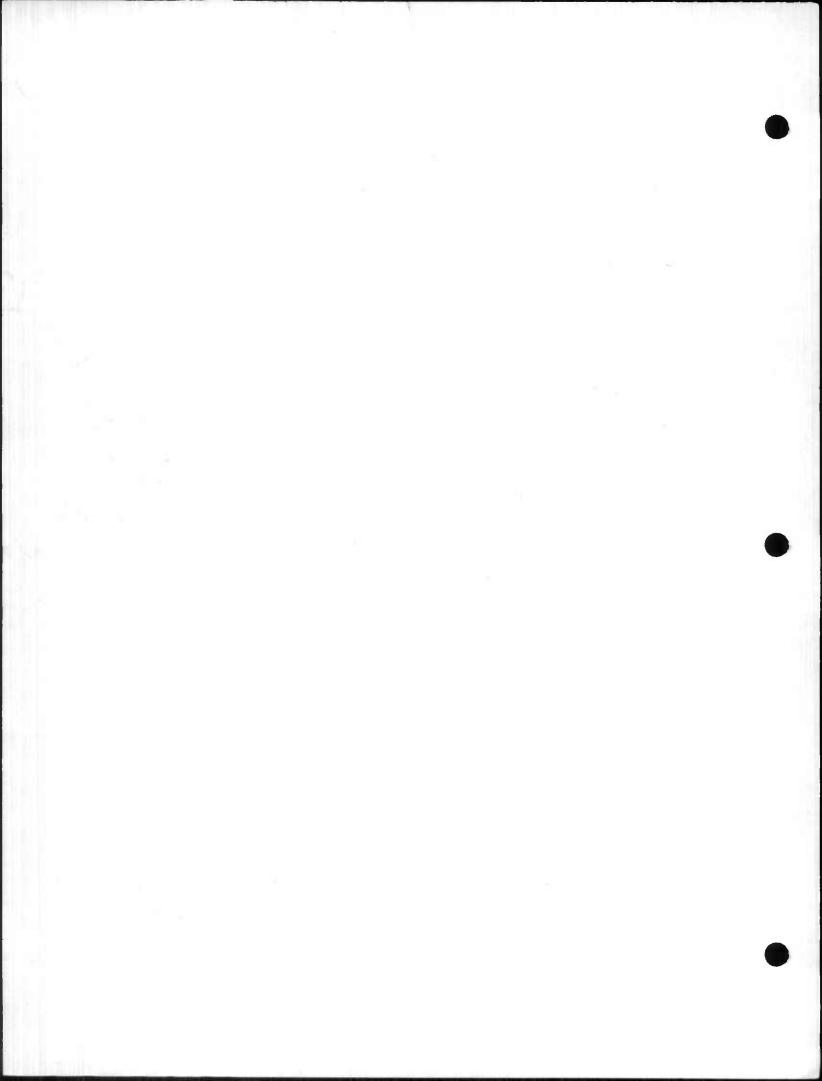
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Hem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

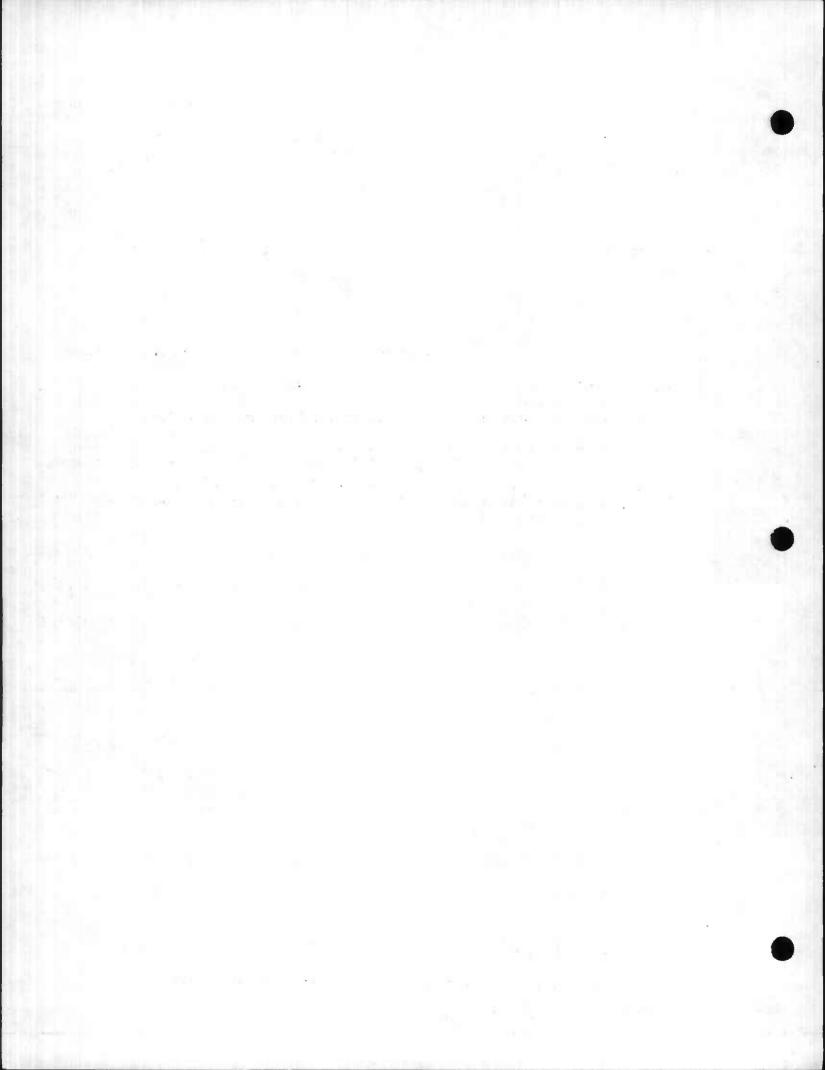
FOR STATE REGISTRAR		STATE OF 1	MARYLAN			CATE C				MENTAL	HYGIEN	E	1.01	02.540	
1. DECEDENT'S NAME (First	t, Middle, Last)									2. DATE	OF DEATH	.v	YEAR	3. TIME OF DEATH	
Mary Carol	ine Me	isel_									Mary		999	05:30 A M	
4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In)	yrs. last b	- "	IF UNDER 1 YE		IF UNDER	24 HRS.	7 DATE	OF BIOTI		8. BIRTH Countr	IPLACE (State or Foreign	
174-38-9097		1 M 2 F		54	YRS.	MONTHS DA	Wa I	HOURS	Öc	tobe	r 2, 1	944		yland	
9a. FACILITY NAME (If not is	nstitution, give s	treet and number)				9b. CITY, TO	WN OR	LOCATE	ON OF DE	ATH	-	9c. COU	NTY OF D	EATH	
277 Blake R	oad					Elkt	on					c	ecil		
RESIDENCE OF DE															
10e. STATE	10b. COUNTY				10c. CITY	, TOWN OR LI	OCATIO	N.						10d. INSIDE CITY LIMITS?	
Maryland	Cec	il				Elkton						-	1 TYES 2 X NO		
10e. STREET AND NUMBER						101. ZIP CODE 10g. CITIZEN OF WHA							WHAT COUNTRY?		
277 Blake	Road								.921					States	
11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN	YES	2 NO						ilC ORIGIN n, Puerto f	? (Specify Yas lican, etc.)	or No-		E — American indian, k, White, atc.	
3 Widowed 4 Div	_	IF YES, GIVE Y	WAR OR DATE	s A		1 🗆	YES 2	XNO	Specify	r:			Spec		
15 DE/	CEDENT'S EDU	CATION	1 4	to DECE	DENT'S	USUAL OCCUI	PATION			1486	KIND OF BU	DINEGO /INI	DUCTOV	White	
(Specify on	ly highest grade	completed)		(Give	kind of w	ork done durin	ng most	of workir	ng	100.	KIND OF BU	SH4E33/H4	DOSINI		
Elementary/Secondary (0-12)	College (1-4 or 5				ployed	A P	ctis	t.	но	ome				
17. FATHER'S NAME (First, A	Airirlia I aet)	3		5011		520700	_				Aiddle, Maiden	Cumamal			
								is. MOII				Sumame)			
Martin 19a. INFORMANT'S NAME (Table	MAH INO	ADDRESS (Or		f bloombar			earer	- David 7	- 0-41		
		/ 1													
C. Julius		/Husband							EIKt		Maryla				
20a. METHOD OF DISPOSIT	on 3 🗆 Ram	ovel Irom State	cemete	erv. creme	story or oti	F DISPOSITIO her place)				DAT			City or To		
4 ☐ Donation 5 ☐ Othe 21. SIONATURE OF FUNER/		PENCEE	Но	ly (Cros				SS OF FA		5/99	Spar	igler	, PA	
21. SIGNATURE OF PURER	AL SENVICE EN) -									erals	. P.2	Α.		
Done	ر بارید	2. Hu	DO.								Stree			, MD 21921	
23. PART i. Enter the c					h. Do n	ot enter the	mode	e ot dy	ing, suc	h aa carc	llac or resp	iratory si	тез1,	Approximate	
IMMEDIATE CAUSE (FI		List only one car			4									Onset and Death	
disease or condition	→	OUE TO	chasi	τ 6	x 1	he L	iv	er						Veurs	
resulting in death)		DUE TO	(OR AS A C	ONSEOU	ENCE OF	7):	-							1	
		. A10												years	
Sequentially list condi- if any, leading to imme			(OR AS A C):									
cause. Enter UNDERLY	ING														
CAUSE (Disease or injuted initiated events	ury	DUE TO	(OR AS A C	ONSEOU	ENCE OF):				7					
reaulting in death) LAS	ST	d													
PART II, Other algnific	ant condition	a contributing to	death but	not rea	aulting i	n the under	rlylng	cause	given in	Part 1.	24a. WAS AN PERFOI		246	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
											1 TYES	NO		OF DEATH?	
														1 _ YE\$ 2 _ NO	
DID TOBACCO U	JSE CONT	RIBUTE TO CA	AUSE OF	DEAT	H YE	S 🙀 NO		UNC	ERTAI	N					
25. WAS CASE REFERRED 'EXAMINER?	TO MEDICAL		26	PLACE	OF DEAT	H (Check only	one)								
1 TES 2 NO		HOSPITAL:	ER/Outpati	ant 3	DOA	OTHER:	Home	5 X R	naldanca	6 🗆 Othe	r (Specify)				
27. MANNER OF DEATH		28a. DATE O	F INJURY Day, Year)		26b. TIME	E OF 280 URY	c. INJUI			26d. DES	CRIBE HOW	NJURY O	CURED		
	Pending Investigation	(Moran,	, 10a1)		1110		YE		NO						
2 Accident 3 Suicide	Could not be	26a. PLACE	OF INJURY -	At hom	a, farm, a	treet, fectory,	offica			261. LOC	ATION (Street	and Numbi	or Rural	Route Number,	
4 Homicide	datarmined	bullding	, etc. (Specify)						Crity	or Town, State,				
29a. CERTIFIER 1 N CER	TIEVINO PHYS	ICIAN: To the best of	t my knowled	ine dest	h 0000000	d at the time	deta a	ad alasa	and du	do the no	(0)		4-4		
anal anny														a) and manner as stated.	
296. SIGNATURE AND THE	ark	פרן ני						D LIC	15	314	4	≥ J.	TE SIONED	(Month, Day, Year)	
H Furka	S, M	D COMPLETED CAL	Wer .	IZ 2,	27) (Type,	Cho so	P	ak	e Ho	spic	e,E	1kt	on,	~ D	
JAN 2 6	999	32. REGISTR	AR'S SIGNAT	MRE	Spor	rela									
-															

12.1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryla		tificate of		Re	g. No.	12341	
Physician	Decedent's Name (First, Middle, Las	1)				2. Data of Death Month	Day Year		
/Medical	Mamie McConnell					January		1320	
Examiner	4a Facility Name (If not institution, give 32 Cami Way	street and number)			4b. City, Town, or Elkton	Location of Death	4c. County of Dec	ath	
Funeral Director	1/3-28-07/1	THE OFFICE	s. last birthday) 9 Yrs.	If Under 1 Year Months Days		8. Data of Birth (Month, Day, May 27,	Year) 9. Bi 1899 Mar	rthplace (Stata or Foreign Country) yland	
death with the Meryland rms 23e or 28e-f show rmst be notified at neral Director	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits	
the Meryle 28s-f sho notified at	Maryland Cecil	E	lkton					1 ☐ Yes 2 ☑ No	
with the Mean or 28s-fa	10e. Street and Number			10f. Zip Code		10	og. Citizen of What C		
ral	32 Cami Way				21921		United S	tates	
urs atter ar, or its by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Datas;		Vas Decedent of f Yes, specify Cut I ☐ Yes 2X No	Hispanic Origin? (S van, Mexican, Puarl Specify:	pecify Yes or No- to Rican, atc.)	14. Race - American Indian, Black, Whita, etc. Specify: White		
mple and and and and and and and and and and	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5+)	16a. Deced (Give lifa. L	16b. Kind of Busines					
D PART O	17. Father's Name (First, Middle, Last)		пошеш	aker	18 Mother's Nar	na (First, Middle, A	In her ow:	n nome	
Maryland 2. 4 2 should be filed v th and Mental Hygle 7 le marked other t treumatic avent, in	Josef Backoff				Anna F	one researched			
ahou nd M	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailin	g Address (Stree	t and Number or Ru	ural Route Number,	City or Town, State,	Zip Code)	
Md 2 md 2 md 2 mg 27 la mg 27	Phyllis Crabtree	/ Daughter	32 C	ami Way,	Elkton,	Maryland	21921		
Baitimore, Maryland : permit. Pages 1 and 2 should be filed Department of Health and Mentel Hys important: if Item 27 It marked other any injury or other treumetic event, ance. To Be C	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify	Presbyterian Cemetery 1999 Newark, Delaware							
Baiti permit. Departm importar any inju	21. Signature of Funeral Service Licens	1FL	22 Hi	. Nama and Addr CKS Home	ass of Facility for Fune	erals, P.	Α.	land 21921	
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that coused the de	1					Approximata	
Physician /Medical	Immediate Cause (Final disease or condition	a. CHW NCC						Interval Between Onset and Death	
Examiner	resulting in death)	Due to	(or as a conseq	uence of):					
P # 5		D. AMENOS	CUERO	TIL CA	MOIO CX	Ruban	MSERE	5 years	
licate be executed physician and site burlaturalit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of): [MIENTENSWE CHADWAR CUMM DISEASE SY							
ficate be availties by physician a set the burlei-	Cause (Disease or injury	· HUPERIE	wsw f	CHRO	wingun	non bise	785	syears.	
cartificate oding physise as the	that initiated events resulting in death) Last	Dua to	(or as a consequ	uence of):					
death cert e attendin of for use									
Physical Phy	Part II. Other eignificant conditions co	ntributing to death but not n	esulting in the ur	nderlying causa g	23b. Did tobacco use contribute to the cause of 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ U				
been sehould						24a. Was ar		. Were autopsy findings available prior to completion of cause of death?	
						1 □ Ya	s 20No	1 ☐ Yes 2 ☑ No	
yelclen: The i yelclen: The i s cartificate hi director, page To Be Corr	25. Was case referred to medical				26. Place of Dea	ath (Check only on			
OT VITAL Physician: This cardificat ribis cardificat ribis Cardificat ribi	avaminer? /	Hospital: 1 tnpatient 2	☐ ER/Outpatien	t 3 DOA OI	hor		nce 6 Other (Sp	ecify)	
Attending Physic actor: After this by the funeral diffication: To	27. Manper of Death 1 ENatural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	iry at ork?] Yas 2 □ No	_	w injury occurred		
0 949 E	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Special	homa, farm, stri cify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or I , State)	Rural Routa Number,	
he Hospital in 24 hours he Funeral pletsly filled edical C	29a. Certifier (Check only one) 1 Certifying Phy one)	sician: To the best of my kiner: On the basis of axami and manner stated.	nowledge, death nation and/or inv	occurred at the trestigation, in my	ima, data and place opinion, daath occu	, and dua to tha ca irred at the tima, da	use(s) and manner at and place, and de	as stated. us to the cause(s)	
within 2 To the comple	29b. Signature and title of certifier			29c. Licen	se number	25	9d. Data signed (Mor	oth, Day, Year)	
	plembel. 4	201.		00-	1463		1-20-4	9	
5	30. Name and address of person who of	impleted cause of death (It				3 3 3	1001		
	Rolando Najera M.I			treet, E	lkton, Ma	aryland 2	1921		
State Registrar	JAN 2 2 1999	32. Registrar's Sig	4 L	and 1					

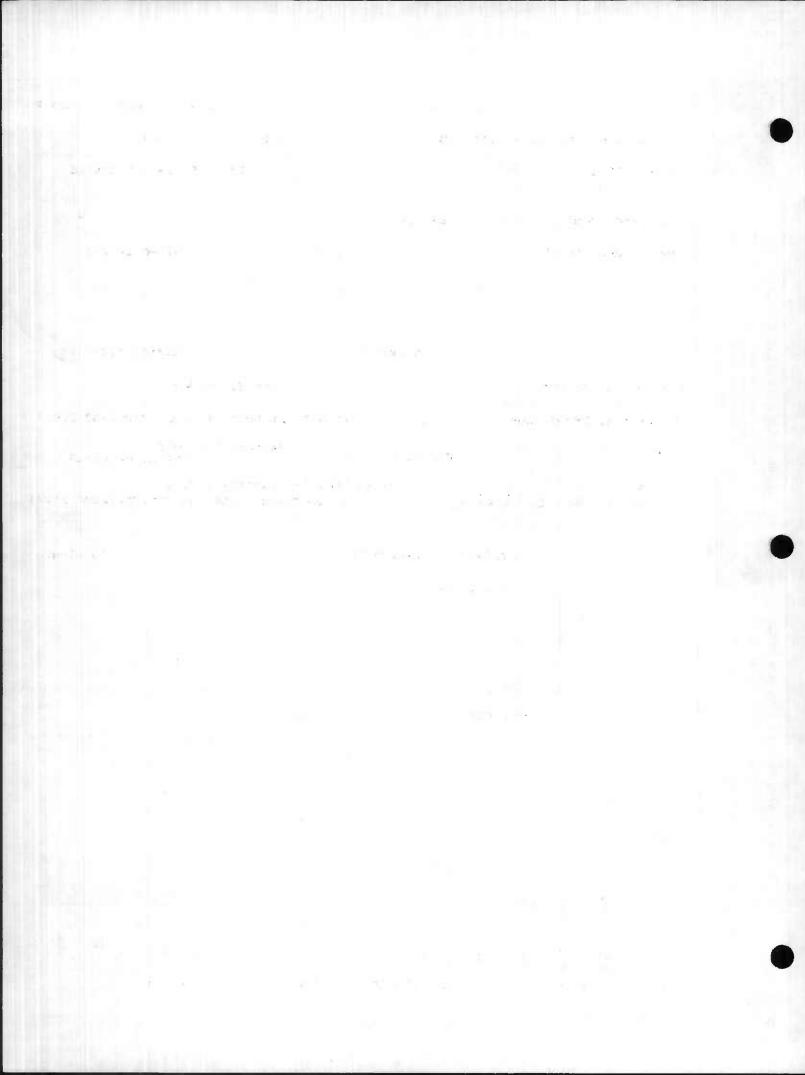


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State of Maryland / Department of Health and Mental Hygiene Q 01,

To Be Completed by Funeral Director	1. Decedent's Name (First, Middla, L. 4a Facility Name (If not Institution, g. Laurelwood Conti 5. Social Security Number 212-01-7521 Usual Residence of Decedent 10a. State 10b. County Maryland Cecil 10e. Street and Number 708 Bridge Stree 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced (Specify only highast g. Elamantary/Secondery (0-12) 7 17. Father's Neme (First, Middla, Las	Trene Anna ive street and number) nuing Care Sex 1 M 20 F 12. Was Decedent E Armed Forces?	Center (In yrs. lest bir 91 10c. City, Town Elkto	Yrs. Months	r 1 Year	b. City, Town, or I Elkton If Under 24 Hrs. Hours Min.	2. Dete of Dee Month January .ocation of Deeth 8. Dete of Birth Month, Dey June 15	Day 18, 19 4c. County Cecil	99 of Death	3. Time of Death 2025 P						
Be Completed by Funeral Director	Laurelwood Conti 5. Social Security Number 212-01-7521 Usual Residence of Decedent 10a. State 10b. County Maryland Cecil 10e. Street and Number 708 Bridge Stree 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highast g Elamantary/Secondery (0-12) 7	t 12. Was Decedent E Armed Forces? 1 Yes, Give	Center (In yrs. lest bir 91 10c. City, Town Elkto	Yrs. Months	or 1 Year	Elkton If Under 24 Hrs.	ocation of Deeth	18, 19 4c. County Cecil	9. Birthpiac	ce (Steta or Forei						
Be Completed by Funeral Director	Laurelwood Conti 5. Social Security Number 212-01-7521 Usual Residence of Decedent 10a. State 10b. County Maryland Cecil 10e. Street and Number 708 Bridge Stree 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highast g Elamantary/Secondery (0-12) 7	t 12. Was Decedent E Armed Forces? 1 Yes, Give	(In yrs. lest bir 91 10c. City, Town Elkto	Yrs. Months	or 1 Year	Elkton If Under 24 Hrs.		Cecil	9. Birthpiad	e (Steta or Forei						
Be Completed by Funeral Director	5. Social Security Number 212-01-7521 Usuai Residence of Decedent 10a. State 10b. County Maryland Cecil 10e. Street and Number 708 Bridge Stree 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highast gentles) Elamantary/Secondery (0-12) 7	Sex 1 M 2FF 7. Age 12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give	(In yrs. lest bir 91 10c. City, Town Elkto	Yrs. Months n or Location		If Under 24 Hrs.	8. Dete of Birth (Month, Dey June 15		9. Birthpiad	ce (Steta or Forei						
Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Cecil 10e. Street and Number 708 Bridge Stree 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highast gentles) Elamantary/Secondery (0-12) 7	t 12. Was Decedent E Armed Forces? 1	91 10c. City, Town Elkto	Yrs. Months n or Location			8. Dete of Birth (Month, Dey June 15	, 1907	Country	e (Steta or Forei						
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Ве Сомр	708 Bridge Stree 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highast generally secondary (0-12)) 7	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No	ver in U.S.	10f. Zi)∤☐ Yes									
Be Comp	11. Marital Status 1 Never Married 2 Married 3 \(\text{XWidowed} \) 4 \(\text{Divorced} \) 15. Decedent's (Specify only highast g) Elamantary/Secondery (0-12) 7	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No	ver in U.S.		p Code		1	10g. Citizen of Whet Cour								
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Ве Сомр	15. Decedent's (Specify only highast g Elamantary/Secondery (0-12)	reel of Detes.	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			ispenic Ortgin? (S n, Mexican, Puert Specity:	pecify Yes or No- p Rican, etc.)		k, Whita, etc	- American Indian, Whita, etc. White						
Be	(Specify only highast g Elamantary/Secondery (0-12) 7	ducation	160	Decedent's Usu	наі Оссию	ation		16b, Kind of Bu	siness/Indus	strv						
Be	7	rada complated)	a complated) ((during most of wor	king			,						
Be	17. Father's Neme (First, Middla, Las	College (1-4or 5-	lege (1-4or 5+) Supervisor					Elkton	Spar	kler						
To Be		(t)		upor vibo		18. Mother's Nar	ne (First, Middle, i									
Ţ	Charles J. Thomps					Mary	E. Snyd	er	,							
Pages 1 and 2 shourment of Health end M tant: if item 27 is marfjury or other traumatifury or other Traumatifury or other traumatifury or other traumatifury or other traumatifury or other traumatifury or other traumatifury			106	Mailing Address	e (Street				State Zin C	'orie i						
	19a. informant's Name/Ralationship Charles W. Brown						Road, Elkton, Maryland 2192									
	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Othar (Spec		cemata	Disposition (Nerv., cramatory or Cemete	othar pled	e) Janu	uary 21, 20c. Location - City or Town, Steta 1999 Elkton, Maryland									
	21. Signature of Funeral Service Lice			22. Name a	nd Addres	s of Facility_										
ğ		0-11-0	for Fun				1 01001									
	220 Port Enter the disease or on	s. There	the death Do	O3 West Stockton Street, Elkton, Maryland 21921 or the mode of dying, such as cardiac or respiratory errest, Approximata												
	23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.									ntarval Between Onset and Death						
	Immediate Ceuse (Final															
	diseese or condition resulting in deeth)	a. MYOCARI	DIAL IN	FARCTION	1				30	minutes						
	Dua to (or es e consaquence ot):															
- in		HYPERTI	ENSION						1							
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m	Saquentially list conditions, if eny, leeding to Immediata causa. Enter Undarlying Ceuse (Diseese or injury				1											
edical	thet initiated avants resulting in death) Last				į											
3				1												
an	Addition				-											
Physician/M	Part ii. Other significant conditions	contributing to death but	ng to death but not resulting In the underlying causa given In Part I.					obacco use cor	ntribute to ti	he cause of deat						
Phy		DEMENUTA					1 □ Y	es 21 No	3 Proba	ibly 4 Unkno						
þ		DEMENTIA					-									
							24e. Was e	n autopsy "med?	evaile	e autopsy findings able prior to						
o e							Faller		of de	pletion of cause eath?						
Completed							1□ Y	es 2 No	10	Yas 2□No						
	25. Was casa referred to medical	T				DC Disea of Day										
o Be	examinar?	Hospitai:			Oth	or. I	th (Check only or	28	40 14 1							
-	1 Yes 2 No 27. Manner of Death	1 L Inpatier	1		OA 28c. injur	4 Nursing F	ome 5 Resid									
Certification:	1 ☑ Naturei 5 ☐ Panding	28a. Date of injury (Month, Day	Year) 200.	njury	Wor	k?	200. Describe II	ow injury occurr	80							
cat	Accident investigati	he		М		Yes 2 □ No	206 Leasting (C	trant and Alvert	as as Chimili	Douts Number						
툳	4 ☐ Homicida datarmine		ry - At home, fa <i>(Specify)</i>	rm, street, factor	ry, office		281. Location (S City or Tow		er or Hurei r	Houra ryumber,						
edical	29a. Certifier (Check only one) 1 Certifying F	hysician: To the best of minar: On the basis of end manner stat	exemination an	, death occurred d/or investigation	at tha tin	na, data end piace pinion, daath occu	, end due to the c rred at the time, o	ause(s) and ma lata end place, a	nnar as stat and dua to th	ed. he cause(s)						
×	29b. Signature end title of certifiar	/	7	29	c. Licens	e number	2	29d. Date signed	d (Month, De	ay, Year)						
	Da. hour	11 6		2		25015		lanuar	4 18	1999						
-	Xuvua	a par	eyne	OTime Dulet	L	25915		ullou	10) 1111						
	30. Name end eddress of person who	- 4				171-4 1	la med and	21021		*						
	Barbara Parey M	.D. / 111 1		gh Stree	et, E	Elkton, N	aryland	71771								
tate																
trar	31. Data filad (Month, Day, Year) JAN 2 2 1999	32. Registra	rs Signeture	Sports												

DHMH 16 Rev 6/95



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	A Sandalla Nama (Salah A					tificate of	Death		Reg. No. 9) (2943
Physician	Decedent's Name (First, M	liodie, Last)						2. Data of De Month	Day	Year	3. Time of Death
/Medical	Aloma Ann McC							Januar	_	999	1425
Examiner	4a Facility Name (If not instit	ution, give street	and number)				4b. City, Town, or	Location of Death	4c. County	of Death	
	Laurelwood Co	-				Towar L	Elkton	_	Cecil		
Funeral Director	5. Social Security Number 216-38-2857 Usual Residence of Deceden	6. Sex 1□ M 2		ge (In yrs. la: 55	st birthday) Yrs.	H Under 1 Yea Months Day:		8. Date of Bird (Month, Da March 2	th y. Year) 2, 1943	9. Birthi Cour Mary	place (State or Foreign http:) Land
show ad at	10a. State 10b. Co.			10c. City,	Town or Lo	cation				1	10d. Inside City Limits
or tems 23s or 28s-f sho miner must be notified at Punaral Director	Maryland Cec	il		Nor	th Ea	st					1 ☐ Yes 2 ☐ No
be northed Director	10e. Street and Number					10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
TI II	302 Lakeside	Drive				219	901		United	Stat	es
by Funaral	11. Marital Status 1 Never Married 25 3 Widowed 4 Divor	Married 1 [Armed Forces? If Yes 1 ☐ Yes 2 ☑ No			Wes Decedent of I Yes, apecify Cu I ☐ Yes 2X No	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	No- 14. Race - American Indian, Bleck, White, etc. Specify: White		
9	15. Dece	dent's Education ghest grade comp	sloterf)		16a. Deced	lent's Usuat Occi	upation	drina	16b. Kind of Bu	ısiness/în	dustry
hpidu	Elementary/Secondary (0-1		llege (1-4or				e during most of wo				
Completed	12				Sewin	g machir	ne operato	or	Garment	Manu	facturing
8	17. Father's Name (First, Mid	dle, Last)						me (First, Middle,		10)	
10	Walter B. Ang							M. McGla			
	19a. Informant's Name/Relat John McClune,			556	19b. Mailing Address (Street and Number of 302 Lakeside Drive,						
	20a. Method of Disposition 1 Burial 2 Cremet	000							tion - City or Town, Stete		
	4 Donation 5 Othe			Asb		emetery				lle,	Maryland
BUCE	21. Signature of Funeral Sen	· -8	مأذ	Cad	10	3 West S	for Fundation Stockton	Street,E	lkton, Ma	aryla	and 21921
ian cal i	23a. Pert1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only one caus		epsis			wng, such es cardia	c or respiratory at	rrest,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximate Interval Between Onset and Death
Examinar		b	n	Joun &	in	FECTION				 	6 MONTHS
Xa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				s a consequ						6 MONTHS 2 YEARS
edical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		Due to (or e			Malnuti	لره		1	2 years
20	Part II. Other significant con-	Sitions contributir	g to death b	ut not resulti	ing in the un	derlying cause o	iven in Part I.	23b. Did 1	lobacco use cor	ntribute to	o the cause of death?
by Physician/M	Diabetes M.	LLITUS	- Tyl	pe 2	Dia	betic	Mephroph	THY: 10	Yes 2 No	3 □ Pro	bably 4 ☐ Unknown
Completed by	Coronary A	rtery ()iscas	2:	ANem	ia.		24a. Was perlo	an autopsy med?	80	ere autopsy findings eilable prior to impletion of cause death?
Be Com								101	res 2 No	10	☐ Yes 2☐ No
8	25. Was case referred to med examiner?						A CONTRACTOR OF THE PARTY OF TH	ath (Check only o	nne)		
9	1 ☐ Yes 2 Ø No	Hospita	1 ☐ Inpatie	ent 2 E	R/Outpatient	a do do do	ther: 4 Nursing H	lome 5□ Resid	dence 6 Oth	er (Specif	(y)
	27. Manger of Death 1 Natural 5 Per 2 Accident		Date of Inju (Month, Da	y Year) 2	8b. Time of tnjury	28c. Inj W M 1[ury at ork?	28d. Describe	how injury occurr	red	0.6 95.1
Certification:		uld not be ermined 28e	Place of Injusted	ury - At hom c. (Specify)	e, ferm, atre	eet, fectory, office		28f. Location (S City or Tox		er or Run	al Route Number,
edicai	29a. Certifier 1 Certi (Check only ane) 1 Medi	cal Examiner: Or	To the best of the basis of manner sta	examination	edge, death n and/or inv	occurred at the estigation, in my	time, date and place opinion, death occu	a, and due to the urred at the time,	cause(s) and ma date and plece, a	nner as s and due to	stated. the cause(s)
Medical Certi	29b. Signature and title of cer	tifier				29c, Licer	nse number		29d. Date signed	d (Month,	Day, Year)
	monte ?						-4478:	3	Januar	ry 1	9,1999
	30. Name and address of personal MONTE M	AKOU5		111	Wes		h STRE	ET,	ELKTON	i, w	10 21921
State Registrar	31. Date filed (Month, Day, Yo	_ /	32. Registr	ar's Signatur	10	and I					

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THE TOTAL TOTAL THE THE THE TENTH OF THE TRANSPORT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month JAMES O'DONNELL McMAH0N January 19 1999 4:40 PM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Charlotte Hall Veterans' Home Charlotte Hall St. Mary's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Day, Year Day, Year Day, Washington, DC 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2□ F Months 728-05-8502 64 Yrs. Usual Residenca of Decedent 10a. State 10b County 10c, City, Town or Location 10d. Inside City Limits Maryland St. Mary's Charlotte Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 29449 Charlotte Hall Road 20622 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces?

10 Yes 2 No 1957 - If Yes, Give Year or Dates: 1963 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public Relations Journalist 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Joseph McMahon Mary Margaret O'Donnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Denise M. Egan/Sister 6810 Lynbrook Drive, Springfield, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Durial 2 Cremetion 3 Removal from State Jan.26,1999 Bryantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 22. Name and Address of Facility
The Huntt Funeral Home, Inc. 21. Signature of Funeral Service Vicensee JOHN P. KNISLEY P. O. Box 156, Waldorf, Maryland 20604 M01164 23a. Part1. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Ceuse (Final diseasa or condition resulting in death) MON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequenca of) Part II. Other significant conditions contributing to peath but not resulting in the underlying cause given, in Part i. 23b. Did tobecco use contribute to the causa of deeth? 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 0 Other: 4 Sturring Home 5 Residence 8 Other (Specify) 27. Manner of Deeth Dete of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 2 Accident 1 Yes -2 No

The law requires that the death certificata be executed pue P.O. Box 68760. McMahon certificate has Vital of this funeral After 1 ame deeth. the Director: filled in by 6

Examiner Physician/Medical þ Completed Be Certification: To To the Hospital within 24 hours of To the Funeral Completely filled

Physician

/Medical

Examiner

Funeral

Director

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Hygiena.

Pages 1 end 2 should be fill ment of Health and Mantal Hant: If item 27 is marked oth jury or other traumatic even

Department of important: If eny injury of once.

mew

Physician

/Medical Examiner

other 1

other traumatic event, the Medical Examiner

the

filed within 72 hours eftar

21215-0020

Maryland

Baltimore.

Director

Funeral

Completed by

3 ☐ Suicide 4 Homicide Medicai 29a. Certifier

6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) To certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner es steled.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated.

29b. Signature and Ne of cartifier

(Check only

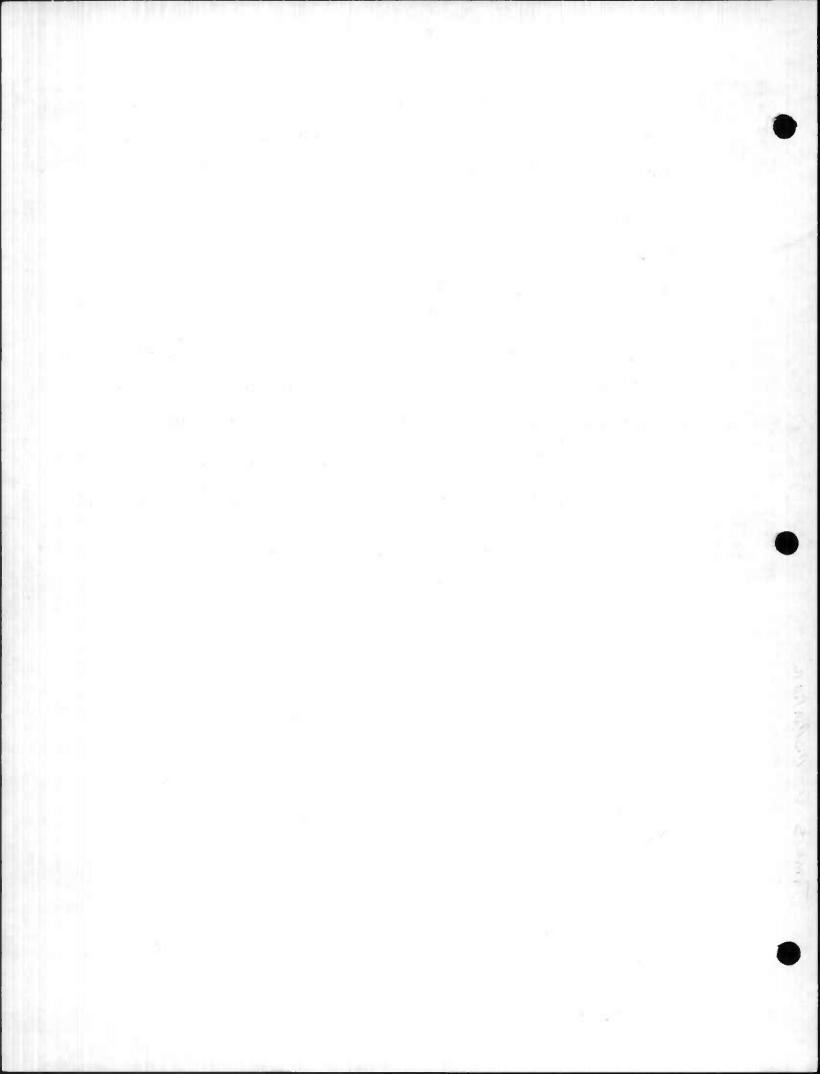
29c. License number D-44436 29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6B PRESTON 58 II 31. Date filed (Month, Day, Year)

JAN 26 1999

32. Registrer's Signature

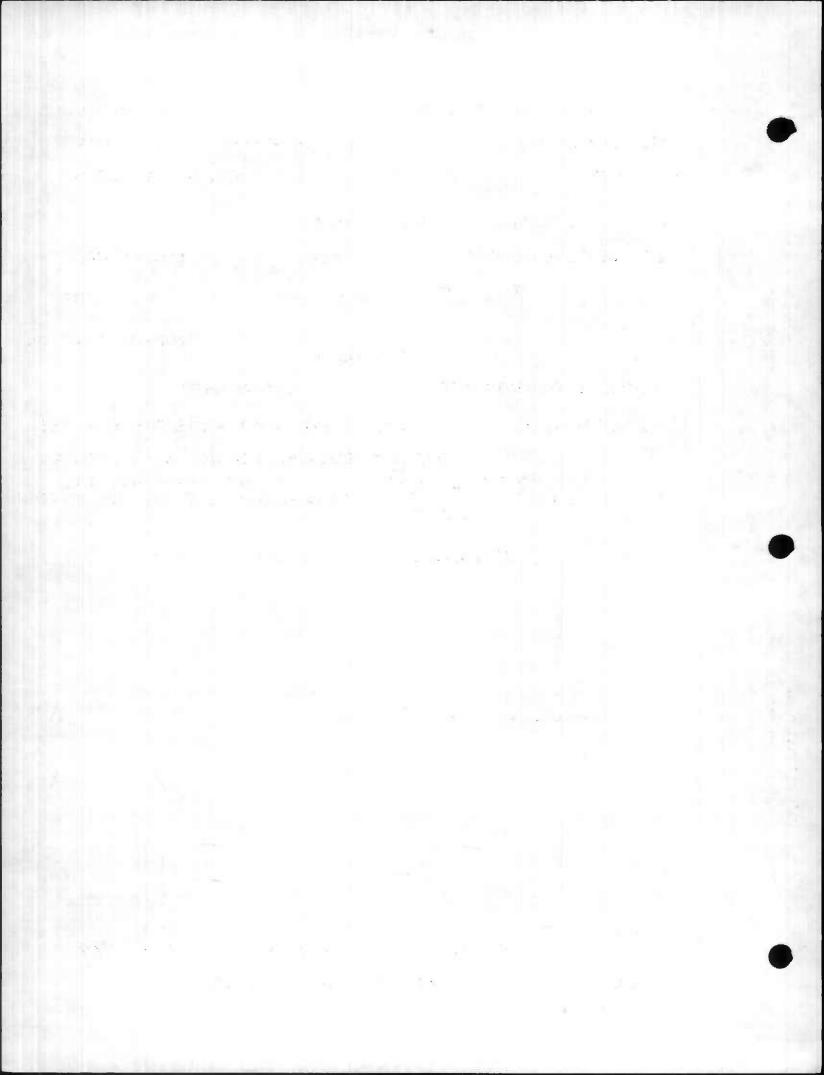
State Registrar



Certificate of Death Reg. No. 1. Decedent'e Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** JACK DEMPSEY MOBLEY, SR. January 22 9:20 PM 1999 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. MARY'S HOSPITAL LEONARDTOWN MARY'S If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months Deys MM 20F Yrs. Director 418-22-2391 70 FEB. 14, 1928 ALABAMA Usuel Residence of Decedent Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Exampler must be notified at 1 Yee 2 No Director ST. MARY'S MECHANICSVILLE 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 37006 WEST LAKELAND DRIVE 20659 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? V☐ Yes 2 ☐ No NAVY If Yes, Give Year or Dates: 1945-49 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) SECURITY STORAGE CO. other than College (1-4or 5+) 12 TRUCK DRIVER Ith and Mental Hygie
7 Is marked other ti 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be CHRISTOPHER COLUMBUS MOBLEY GRACE MAE WALKER and I 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st Department of Haalth and Important: If them 27 Ia n any injury or other traun once. JACK D. MOBLEY, JR. 15711 BALD EAGLE SCHOOL RD. BRANDYWINE, MD 20613 20b. Placa of Disposition (Nama of cametery, cremetory or other pleca) 20e. Method of Disposition 1 D Buriel 2 Cremetion 3 Removel from State TRINITY, MEMORIAL GARDENS 1/26/99 WALDORF, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funarel Service Licenson 2. Name end Address of Fecility HUNTT FUNERAL HOME, INC. DAVID A. GOFF M01095 1 3035 OLD WASHINGTON RD. WALDORF, MARYLAND 20604 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each life. Approximete Interval Between Onset end Death **Physician** immediate Cause (Finel disease or condition resulting in death) nwegicar PROBABLE MYDEARDIAL ENFARETION **Examiner** Dua to (or as a consequance of) Physician/Medical Examiner attanding physician and I for usa as the burial-transit The lew requires that the death certificate be executed Sequentielly list conditions, if eny, laading to immediate causa. Entar Underlying Ceuse (Diseese or Injury that initiated evants resulting in deeth) Lest Due to (or es e consaguança of) P.O. Box 68760, Dua to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 6 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CAREWOMA OF The Bladder of Vital Records, þ cata hes been sig 24b. Were eutopsy findings available prior to completion of cause of daeth? 24e. Was en eutopsy Completed performed? 1 Yes 2 No After this certificate Physician: 25. Was cesa raferred to medical Be 26. Piaca of Death (Check only ona) examiner? Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No s after death.

I Director: After this od in by the funeral d 27. Magner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: or Attending 1 Netural 5 Panding investigation 1 ☐ Yes 2 ☐ No 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in edical 10 Certifying Physician: To the best of my knowladga, daath occurred et tha tima, date end placa, end dua to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and placa, end due to the cause(s) end manner statad. 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1-23-99 1) 14285 30. Name end eddrass of person who completed cause of death (Itam 23a) (Type, Print) WILLIAM D.BOYD M.D. P.O.BOX 1753 LEONARDTOWN, MD. 20650 31. Date filed (Month, Day, Year) JAN 26 32. Registrar's Signature State 1999 Registrar

JACK DEMPSEY MOBLEY



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ()

10f. Zip Code

20746

1 ☐ Yes 2 ☐ No Specify:

Hours

0	2	\circ	1	1
11	/	61	10	1
U	6	14	1	0

Year

1999

10g. Citizen of What Country?

United States

Specify:

16b. Kind of Business/Industry

14. Race - American Indian, Bleck, White, etc.

BLACK

NOV 16, 1977

3. Time of Death 1902 PM

Birthplace (State or Foreign Country)

Washington, D.C.

10d. Inside City Limits

Approximate Interval Between Onset and Death

completion of cause of death?

1 Yes 2 No

JANUARY 7, 1999

1 Yes 2 □ No

CORNELL	M.	MATHIS
	4	1/3
Physic	ian	1. Decedent's

Certificate of Death /3 ent's Name (First, Middle, Last) 2. Date of Death Day Month CORNELL MATHIS JANUARY 6, /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6200 BLOCK OF OXON HILL ROAD OXON HILL PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Days Months

Funeral Director

r than "natural", or items 23s or 28s-f ahow the Medical Example: must be notified at ş death al Hygiena. I other than "natural", or iter

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked oths eny Injury or other traumatic event, phose.

Baitimore, Maryland 21215-0020

Physician /Medical Examiner

68760

Box

P.O.

Records,

Division of VItal

attending physician and for use as the buriel-transit requires that the death certificate be axecuted ed by the datached signed by t d be datach Completed 8 10 this After thi Certification:

or Attending efter deeth.

Director: After de in by the fun Mospital of 24 hours e Funeral D Pelli To the I within 2 To the F

6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 21 579-98-5796 Usual Residence of Decedent 10c. City. Town or Location 10e. State 10b. County Maryland | Prince Georges Suitland 10e. Street and Number 5208 Belgreen Street #201 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 Merried à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 17. Father's Name (First, Middle, Last) Cornell Mathis 19a. Informant's Neme/Reletionship (Type, Print) Emma Lee Mathis /Grandmother 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Experal Service Licenses M859 Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last by

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Worker Private 18. Mother's Name (First, Middle, Maiden Sumame) Shirley Truesdale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5208 Belgreen St., #201 Suitland, Md. 20746 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1/15/99 Washington, D.C. Mt. Olivet Cemetery 22. Name end Address of Facility ALEXANDER S. POPE FUNERAL HOMES 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one dause on each line. Due to (or as a consequence of) Due to (or as a consequence of) Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to 24a. Wes an autopsy performed? 1 VYas 2□ No 25. Was case reterred to medical 26. Piace of Death (Check only one) 1 Xes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury Fo wheels. Time of Fo unit C. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 16/99 Subject 1 Naturat 1 Yes 2 No 1902 М 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number City or Town, State) 4 Homicide 6200 Block Oxon Hill Rd - Found treet

29a. Certifier (Check only one)

Josep

31. Date filed (Month, Day, Year) JAN 1 9 1999

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signetury and title of certifier

ectanis 30. Name and actress of person who completed cause of death (from 23a) (Type, Print)

Kestaner 111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

Registrar

edical

2. Registrar's Signatur

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Michae 1999 15, January 17:58 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/28/1931 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Hours Days Months 1⊠M 2□ F Yrs. 67 North Carolina 577-40-3957 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Forestville 1 Ves 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 USA 1317 Alberta Dr. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marifal Status Black, White, etc. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates: 1 Never Merried 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Towing Etamentary/Secondary (0-12) College (1-4or 5+) Tow Truck Operator Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yates P. Mauney Fave E. Michael 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 9216 Midland Turn, Upper Marlboro, MD 20772 Curtis Mauney/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from Stete Metropolitan Crematory 1/16/99 4 □ Donetion 5 □ Other (Specify) Alexandria, Virginia Juneral Service Licensee George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feiture. List only one cause on each line. Approximate Interval Between Onset end Death Immedieta Causa (Finat disease or condition resulting in deeth) Dua to (or as a consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enfer Underlying Causa (Disaase or injury that initieted events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 2X No 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 1 □ Yes 2 □ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Menner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Natural 5 Pending investigation

The law requires that the death certificate be executed the burial-trans Box 68760. for use P.O. Division of Vital Records, certificate or Attending Physician: this After

Examiner Completed by Physician/Medical Be Medical Certification: To

Physician

/Medical

Examiner

Director

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Pages 1 and 2 should be nent of Health and Mental

it of Health a If Item 27 is or other tra-

Physician /Medical

Examiner

72 hours after

Baltimore, Maryland 21215-0020

24 hours after death. • Funeral Director: A Within 2 To the F 8

31. Deta filed (Month, Day, Year) State JAN 1 9 1999 Registrar

2 Accident

4 Homicide

29b. Signafuse and title of certifier

3 Suicide

29e. Certifier (Check only one)

CAROUN HAMMETT, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

1 □ Yes 2 □ No

Pate signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be detarmined

344 UNIV. #326 SILVER SPRING,

32 Registrar's Signature

28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

DHMH 16 Rav 6/95

JAN 1 9 1933

Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Deeth Month Day Year **Physician** 03:06 MATTOCKS 160 99 10 /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner OFO heverly Hospita GEO RINLA PRIME If Undar 24 Hrs. If Under 1 Year 8 Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 10M 20F Months Days Hours Min 238-50-4204 64 Yrs. 02-04-NORTH CAROLINA Director Usual Residence of Decedent 15 the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at X☐ Yes 2☐ No Director VA ALEXANDIA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7945 AUDUBON AVE 22306 UNITED STATES Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black White etc 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) filed within other than Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be fill mant of Haaith and Mental Hy ant: if Item 27 is marked other ury or other traumatic avent JAMES JONES BETSY GIBBS 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAXINE CARTHENS / DAUGHTER 2141 ROBERT BOWIE DRIVE, UPPER MARLBORO, MD 20774 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stata Buriel 2 Cremation 3 Removal from State permit. Page Department of Important: If I any Injury or pace. 4 ☐ Donation 5 ☐ Other (Spacify) JONES FAMILY CEMETERY 1-24-99 SILVERDALE, N.C. 21. Signatura of Junaral Service Licensee 22. Nama and Addrass of Facility Pope Funeral Home
5538 MARLBORO PIKE, FORESTVILLE, MD 20747
t enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** RESPIRATORY ARREST /Medical Immediate Cause (Finel disaase or condition rasulting in deeth) Examiner Due to (or as a consequence of) Esuphageal CARCINOMA Examiner (erminal that the death cartificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as e consequence of): Box 68760 Physician/Medical Dua to (or as e consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the ceues of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. À 24b. Were autopsy findings available prior to should should 24e. Was en autopsy Completed completion of causa of death? W.B paga Tha 200 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificata Physician: director 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2DER/Outpatient 3□ DOA this Aftar thi 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours aft the Funeral Di nplately filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier edical To the F within 2 To the F 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signature and little of confil 20/99

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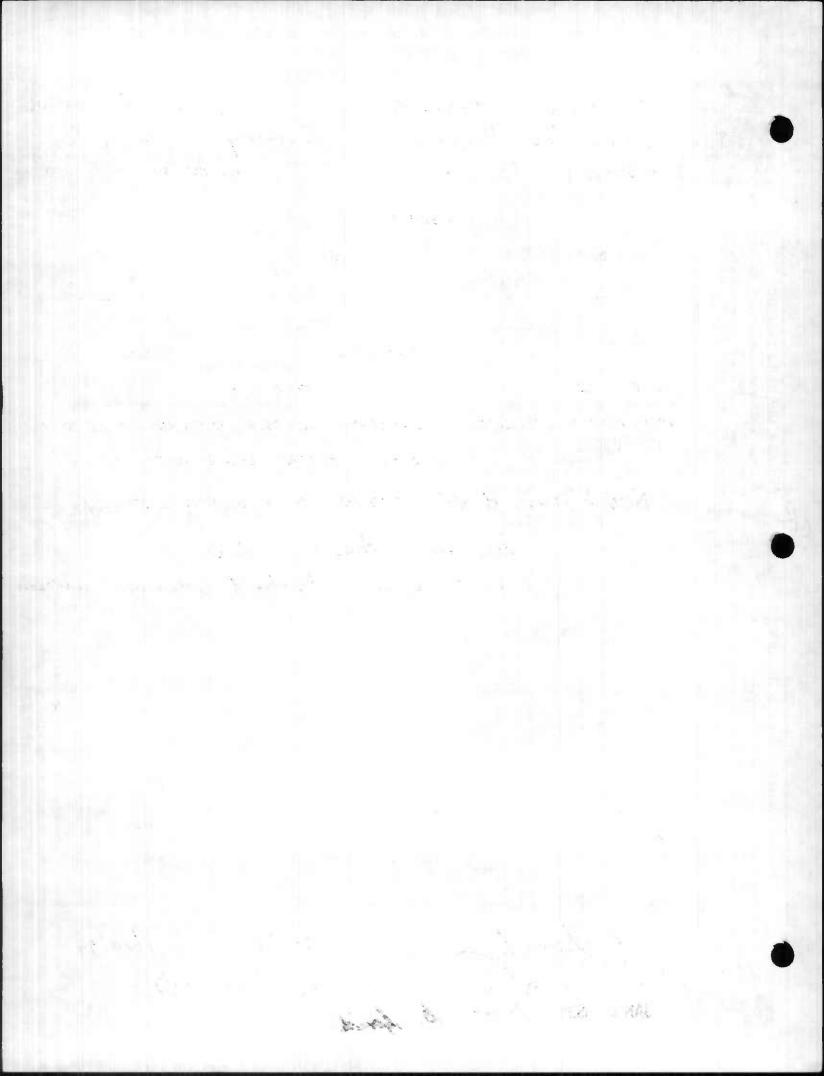
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32. Registrar's Signature

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Yeal) JAN 2 1 1999

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

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State Registrar 31. Dete filed (Month, Day, Year) JAN 2 1 1999

DENNIS J. HAND, M.D. 4203 QUEENSBURY ROAD, HYATTSVILLE MARYLAND 20781

Secretary by the second second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Yaar **Physician** Marshall Thelma 14, 1999 10:00 A.M January /Medical 4b. City. Town, or Location of Death 4a Facility Nema (If not institution, giva street end number) 4c. County of Death Examiner Prince George's 7300 McMillen Drive Clinton If Under 1 Yaar | If Undar 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months Hours 1□M 20 F Yrs. 86 Director Feb. 20, 1912 Cinderella, W.VA 579-28-3880 Usual Residence of Decedent death with the Marylend 10a. Stata 10c. City, Town or Location 10d. insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yas 2 No Directo Maryland Prince George's 10g. Citizen of What Country? 10e. Sfreet and Number 10f. Zip Code 7300 McMillen Drive 20735 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? permit. Pages 1 end 2 should be filed within 72 hours affer of Department of Health and Mental Hygiena. Introcrant: if frem 27 is marked other than "natural, or free any injury or other traumatic event, are traumatic event, any injury or other traumatic event, are traumatic event, and any injury or other traumatic event, are traumatic event, and any injury or other traumatic event, are traumatic event, and any injury or other traumatic event, are traumatic event, and 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0020 1 Yas 2 No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Government Elementary/Secondary (0-12) College (1-4or 5+) Technician Bureau of Engraving 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Wiley Patterson Cornelia Roy 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Venita A. Murphy 7300 McMillen Drive, Clinton, MD 20735 Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery 1/23/99 Suitland, MD 22. Name end Address of Facility
STEWART FUNERAL HOME, Inc. 21. Signeture of Funeral Sarvice Licansi 4001 Benning Road, N.E., Washington, D.C. 20019 and. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximeta Interval Between Onsal end Death **Physician** /Medical immediate Cause (Final Heart Failer lars ' disaase or condition resulting in death) Examiner Examiner requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in death) Last physician and s the burial-tran Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): USB BS Ö Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown signed l Diferen P 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peen complation of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Hospital or Attending Physician: 24 hours after death. Funeral Director: After this centifica director. Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicida 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide **Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

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**Discretifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifie (Check only one) end mannar stated. To the Within 2 To the 29c. License number 29b. Signature and title of certifler 29d. Date signed (Month. Day. Year) D 2635 2 30. Name and eddress of person and con ted cause of death (Item 23a) (Type, Print) 9/31 Officataway Ad 31 Date filed (Month, Dey, Year) 132. R State JAN 2 1 1999 Registrar

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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notified at						ZEUOII							Yas 2 No
Directo	Maryland 10e. Street and Nur	Prince Ge	eorge's	Lan	dover	10f. Zip	Code			10a. Citiza	en of What	t Country?	
	6803 Cent	ral Hills	s Court				207	85			S.A.		
by Funeral	11. Marital Status	ied 2 Married	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? 9 No	If	Vas Deced Yes, spec	dent of H cify Cuba	lispanic Origin? (San, Mexican, Puer Specify:	Specify Yas or f to Rican, atc.)	No- t	4. Race - A	American India White, etc. Blac	
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ruse as the burlel-transit incal an/Medical Examiner	Immediata Cause (disease or condition resulting in death) Sequentially list confirm, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death) in the condition of the conditio	enditions, nmediata orlying injury	b. Cu c. Hep	ati	Pras a consequence of the conseq	uence of):	10	И					end Death Nowth Lears
Physician/M	Part II. Other signif	icant conditions of	ontributing to death	but not res	ulting in the un	derlying c	ausa giv	en in Part I.	1	d tobacco u		bute to the ca	use of death?
Completed by P									24a. W	as an autops rformed?	T -	4b. Wara auto	opsy findings
Comp									t [⊒Yes 2⊠	LNo	t 🗆 Yes	200 No
B God	25. Was case refare examiner?	red to medical	Managaria d				011	26. Place of De	ath (Check onl	y ona)			
0	1 Yas 2	-			ER/Outpatient			4 LI Nursing	Homa 5□Ra			Specity)	
ed in by the tunera Certification:	27. Manner of Deati 1 Senatural 2 Accident 3 Suicide	5 ☐ Pending investigation 6 ☐ Could not be			28b. Time of Injury	М		y at k? Yes 2 □ No	28d. Describ			or Rural Routs	Number
completely filled in by the funeral Medical Certification: 7	4 Homicide 29a. Certifier (Check only ane)	determined Certifying Phy Medical Exam	building,	etc. (Specif	wledge, death	occurred	et the tir		City or 1	own, Stata)	and menne	er as stated.	
M	29b. Signature and	titla of certifier				290	. Licens	e number		29d. Data	signed (N	Aonth, Day, Yo	ser)
)	RA	Anala	Uson	_			D5	2381		1	1/3	199	
	30. Name and address	ess of person who o		f death (Iten	23a) (Type, F	Print)	00	015	ilver		. 1./	ha	910

DHMH 16 Rev 6/95

deel collaboration

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #1, Certificate of Death 1/25/99, rjw, Cecil Co.

1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth **Physician** Doris 02:06 Thuary, 20 1999 tion of Deeth 4c. County of Death Dorothy L. Pavlik /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner E1kton

If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Yei
December 5, Union Hospital Cecil 5. Sociei Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2⊠F Vre 74 Director 221-12-4401 1924 Delaware Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at Maryland Cecil Elkton 1 Yes 3€ No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 55 River Road 21921 United States Pages 1 and 2 should be filed within 72 hours efter death vener of ether death veneral the file of the state Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritai Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2X No Specify. þ 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 9 Owner/Operator Gas Station 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Horace Amos Levering Lavenia 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 418 Longfield Road, Newark, Delaware 19713 Sallie Lee Midash/ Daughter 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Locetion - City or Town, Stete January 23, 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State Wilmington, permit. Page Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) Silverbrook Cemetery Delaware 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland Huke 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel PNEUMONIA DAYS disease or condition resulting in death) Examiner Due to (or es e consequence ot): Examiner CHRONIC OBSTRUCTIVE PULLOWARY DUSEASE buriel-transit that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or es e consequence of) Box 68760. physician the burie Physician/Medicai thet initieted events resulting in death) Lest Due to (or es e consequence ot): 98 signed by the e P.0. Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Nas 2 No 3 Probably 4 Unknown Osteo porassi Records, by 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed Insuliu Dependant Diabeter Mellitus page 2 certificate 1 ☐ Yes 2 10 No 1 ☐ Yes 2 PNo Division of Vital or Attending Physician: funeral director. 25. Wes case reterred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitai: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3□ DOA this 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending efter death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, tactory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the ceuse(s) end menner stated. 29e. Certifier Medical completely (Check only one) within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2 MD 11554000 10 30. Name and address of person who completed cause of death (item 23a) (Type, Print) GAR-EL DAVID North East Maryland Mauldin Avenue 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar JAN 2 2 1999

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	Plea	se Type or								_	_	lble.		
		State	i Mary	iand / i		riment d ificate				nental Hyg	Reg. No.	0	295	53
1. Decedent's Na	ame (First, Middl	e, Last)								2. Date of Dee		Year	3. Time	e of Death
STEVE	EN	DWA	YNE			PIER	CE			JANUA	RY 14	1999	1:4	48 am
4e Fecility Neme	e (If not institution	n, give street and nu	m <i>ber)</i>				41	b. City, To	wn, or L	ocation of Deeth	4c. Coun	ty of Death		
PRINCE	GEORG	ES COMM	UNITY	Y HOS	SPIT	AL	C	CHEV		Y	PRINC			
578-82 Usual Residence	-7164	6. Sex 1 X M 2 □ F	7. Age (In	yrs. last bi	rthday)_ Yrs.	Months D	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 10-16-	(, Year)	9. Birthp Cour WASH		te or Foreign
10a. State	10b. County		100	c. City, Tow	n or Loc	ation						1	Od. Inside	e City Limits
MD	PRINC	E GEORG	ES	CAPI	TOT	HEI	GHT	rs					1 X Y	res 2 □ No
10e. Street and I		D OBORO.		OIII .	LIUI	10f. Zip Co				T	10g. Citizen of	Whet Cour	ntry?	
726		VENIIE						743			п.	S.A.		
11. Marital Statu		12. Was Dec	edent Ever	in U,S.	13. W	as Deceden	t of His	spanic Or	igin? (Sp	ecify Yes or No-	14. Re	ce - Americ	en Indien	١,
	amied 2¶ Man	IT YAS (a	2 No			Yes, specify Yes 2		Specify:		Rican, etc.)		ack, White, ity: BL		
	15. Deceden			168		ent's Usual C			4 =6=	da a	16b. Kind of	Business/In	dustry	
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	ne (First, Middle,	Last)					T	18. Moth	er's Nem	e (First, Middle,	Maiden Suma	me)		
ALO	NZO		PIE	RCE,	JR	•		YV	ONN	E	В	LOUN'	Г	
19a. informant's	Name/Relations	hip (Type, Pnint)	198	19	o. Malling	Address (S	treet a	ind Numb	er or Rui	ral Route Numbe	r, City or Tow	n, State, Zip	Code)	
ANNIE I	L. PIE	RCE - WI	FE	.7	26 !	59th	AV	E.,	CAP	ITOL H	EIGHT	S, MI	D 20	743
		3 □Removel from	State	cemete	ry, cremi	ition (Name atory or othe TON N	r place		EM.	1-19-	20c. Location			•
21. Signature of	Funeral Service		caused the	death. Do	Ti		'S	FU TH C	NER	AL HO	ME ., NW	WASI	H • DC	
Immediate Caus disease or cond resulting in deat	lition	a		ATSC		FAJL	VR	Ē					ч	Days
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	444	b	RENI			5 L U/	r E						4	DAYS
if any, teeding to	immediate			to (or as a							-			
cause (Disease that Initiated eve	ents	c		to (or as a		ence of	1 ~ 1	4		INEOIN	4 G		4	9 A75
resulting in deat	h) Lest		200	10 (01 83 8	consequ	01100 017.							. ~	
		d	AIC	04101	A	3 43 15							15	7508
Pert II. Other sig	nificant condition	ons contributing to d	eath but no	t resulting	in the un	derlying caus	se give	n in Part	1.	23b. Did t	obacco use o	ontribute t	o the cau	ee of deeth?
											Yee 2□No			4□ Unknown
										24a. Was perlo	an autopsy rmed?	av	ere autop vailable prompletion deeth?	esy findings for to of ceuse
										100	on o□No	1	DVac :	all/No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Physician /Medicai Examiner

Department of Health and Mental Important: If Item 27 is marked o any Injury or other traumetic eventos.

Physician

/Medical

Examiner

Funeral Director

with the Maryl

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23e or 28e-f ahow traumetic event, the Medical Examiner must be notified at

d Hygiene.

1 ☐ Yes 2X No

1 Natural 2 Accident

3 Suicide

29e. Certifier

4 Homlcide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
JAN 2 6 1999

Director

Funeral

by

Completed

Be

To

signed by the a cate hes been sig , page 2 should b certificate hes the funeral director, filled in by

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Pert II. Other significant condit by Completed 25. Was case referred to medical examiner? Be Certification: To 27. Menner of Death

attending physician and for use as the burial-transit

The law requires that the death certificate be executed To the Hospital or Attending Physician: hours after death.

Division of Vital Records, P.O. Box 68760,

rithin 24 hours of pompletely. 10

State Registrar

Medicai

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) SAMUEL E. WILSON

5 Pending investigation

6 Could not be determined

3001 HOSPITAL DRIVE, CHEVERLY, MD 20785 2. Registrar's Signature

28b. Time of tnjury

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Hospital: 1 Tinpatient 2 ER/Outpatient 3 DOA

28e. Dete of tnjury (Month, Day Year)

ويذيب

28c. tnjury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

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\$200.40 g I III III III II II 11 10 1 The arranding of the second

	Physic /Medi Exami	ical
	uneral irector	
Aaryland	r show	'n

28a-I with the "natural", or items 23s or

Physician /Medical Examiner

physician and the burial-transit the death certificata be executed 88 980 signed by the e certificate has b this funeral

Box 68760, P.0. Division of Vital Records, Attending Physicien: death. aftar death Director: n 24 hours after des ne Funeral Director nletely filled in by th ŏ Hospital To the Hosp within 24 hos To the Fune completely fi

3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month JANUARY 3, 1999 1:35 A.M. NANCY JOYCE PRUDEN 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S if Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□ M 2 KF Months Deys Hours Min Yrs. 585-38-9714 51 FEB. OHIO 12, 1947 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND PRINCE GEORGE'S BOWIE Direct 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4802 RIVER VALLEY WAY 20715 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, While, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 NEVER WORKED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 HOMER PRUDEN URSULA (UNKNOWN) 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) VOLUNTEERS OF AMERICA, CHESAPEAKE 7901 ANNAPOLIS RD., LANHAM, MARYLAND 20706 MARY LYNN LOGSDON, ADMINISTRATOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 1/13/99 BRENTWOOD, MARYLAND 21. Signature of Funeral Service License 22. Nama and Address of Facility FORT LINCOLN FUNERAL HOME mans 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 f 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) CARDIAC ARREST IMMEDIATE Due to (or as a consaquence of) Examine **HYPERTENSION** Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that Initiated avants resulting in death) Last Due to (or as a consequenca of): DIABETES MELLITUS Physician/Medical Due to (or as a consequence of): UROSEPSIS 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yss 2 ☐ No by 24b. Wara autopsy findings avellable prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 No 25. Was case raferred to medical examinar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and titla of purtilier 29c. License number 29d. Date signed (Month. Day. Year) D 53411 JANUARY 14, 1999 30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

3060 MITCHELLVILLE ROAD, #103, BOWIE, MARYLAND 20716

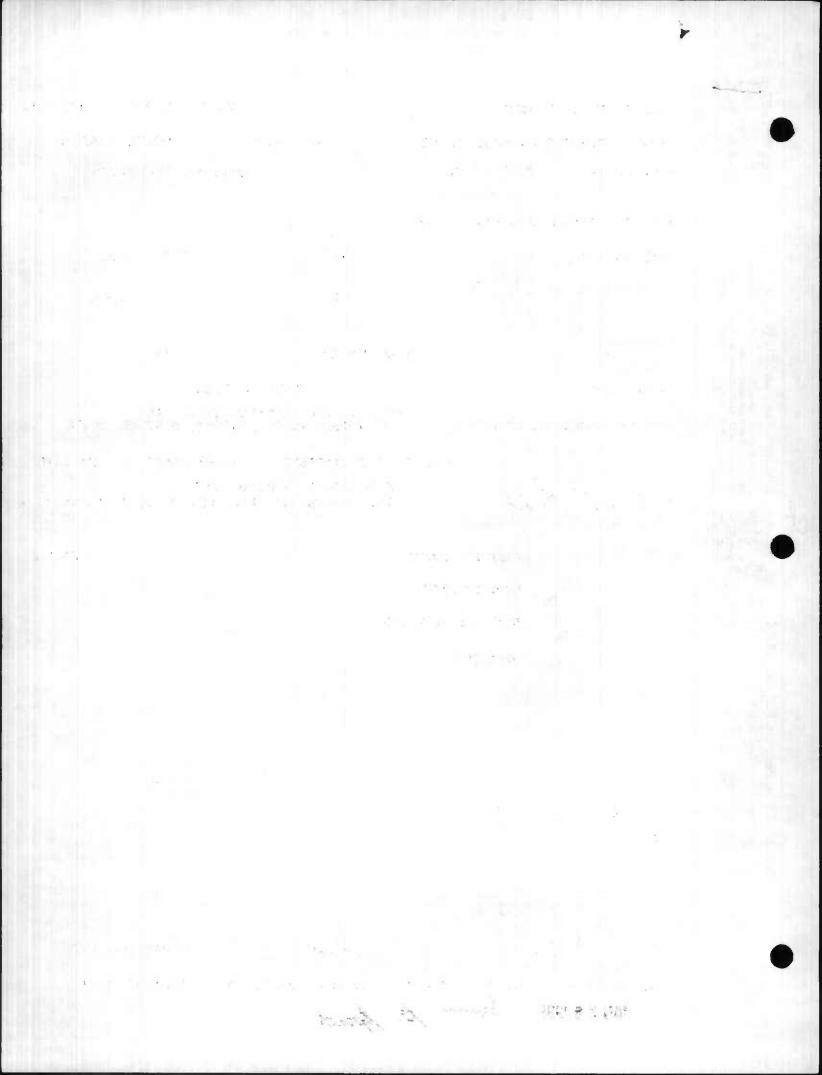
DHMH 16 Rev 6/95

State Registrar J.C. SHESADRI, M.D.,

31. Date filed (Month, Day, Year)

JAN 2 9 1999

32 Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 02955

					Cei	rtificate	e of	Death		R	eg. No.	Sec. 15-	200	,
		1. Decedent's Name (First, Middle,								2. Date of Dear		Year	3. Time of [Death
Physicia /Medic		Charles H. Pa	arham, J	r.						January	16, 19		16:2	28
Examin		4a Facility Neme (If not institution,	give street and nu	ımber)			4			ocation of Death	4c. County	of Death		
		Southern Mary	land Hos					Clin				e Geor	_	
Funeral			S. Sex 1⊠ M 2□ F	7. Age (In yrs.		If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Nov 12	Year)	9. Birthplac	ce (State or	Foreign
Director	-	218-02-6090	IM W ZU F	32	Yrs.					Nov. 12	, 1966	Greenw	ich,	Ct.
B 8-	+	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						100	d. Inside City	v Limits
20 sher death with the Maryland or Neres 23s or 28s-1 show sminer mast be notified at	ò	Maryland Prince	George's		linton								1₺ Yes	1.734
176 Double	Directo	10e. Street and Number	000180		, I I I I I I I I I I I I I I I I I I I	10f. Zip (Code			1	0g. Citizen of	What Country	v?	
38 or		9211 Stuart Ln.					207	35			Unite	d Stat	es	
death Limit	Funeral	11. Meritei Stetus	12. Wes Dec	edent Ever in U.	S. 13. 1	Wes Deced	ent of H	lispanic Ori	gin? (S	pecify Yes or No- o Rican, etc.)		ce - American		
o allo		1⊠ Never Married 2 Marrie	Armed Fo	2 No NT		1 Yes, speci 1 ☐ Yes 2				o Hican, etc.)		ck, White, etc		
5-0020 72 hours after natural, or its dicel Examine	l by	3 Widowed 4 Divorced	If Yes, Gi Yeer or D	14.0		ILI Tes 2	ER MO	эреспу.			Specif	Black	:	
72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual kind of worl	k done	durina mos	t of wor	king	16b. Kind of B	usiness/Indu	stry	
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Merital Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam	dw.	Elementary/Secondary (0-12)	College (life. I	DO NOT use	e retired	9)						
d 2 Had with the control of the cont		12th 17. Father's Name (First, Middle, Li	ant)		Tru	ck Dr	ive		do Alam	ne (First, Middle,	Priv			
and and and and and and and and and and	m									Evans	Vidiueli Surrar	nej		
anyla should nd Men marks umaris	2	Charles H. Parh 19a. Informant's Neme/Relationshi			10b Mailie	na Addrage	(Strant			ral Route Number	City or Town	State 7in C	'oda)	
Magaga Ma		Elaine Tucker /								ple Hill		2074	-	
Te, N 1 and Health lem 27 other tr	-	20a. Method of Disposition		20b. P	Mace of Dispo	sition (Nam	e of		1	•	20c. Location	- City or Town	n, Stete	
Pages name of nry or o		1X Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		Stete	Resurre	,		,	v (1	/22/99	Clintor	Md		
Baltimore, semit. Pages 1 at Repartment of Hea mportant: If Item: iny Injury or othe BRGs.		21. Signature of Funeral Service Li				. Neme and				. 1 2 2 1 3 3	OTTHEOL	i, ma.		
W FORES		1 tito	Carn		Į.	lexan	der	S. P	ope	Funeral	Homes	M 1 -	1 20	7/7
	\forall	23a. Part1. Enter the disease, or conshock, or heart feilure. List or	dmplications that	caused the deat						/Foresty		. A	Approximate	9
Physician		snock, or near fellure. List of					_					i C	nterval Betw Onset and D	reen leeth
/Medical		Immediate Cause (Final disease or condition	k	520,0	ATORN	. 1	201	1100		0		!		
Examiner		resulting in death)	a	Due to (o	r as a consec	mence of):	7170	VICE		1		1		
n *	ner		- PN	U & UMD	0.011	TIS	G	HUNI	,	Prsvmo.	MA	j.		
Box 68760, seth certificate be executed attending physician and for use as the burial-fransit	edical Examiner	Sequentially list conditions,	0.	Due to (o	r es a conseq	uence of):						i		
Sian s	0	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		A.T.)	DS									
68760, filcate be expensed by the purial as the burial	dica	that initiated events resulting in death) Lest	0.	Due to (or	r es e conseq	uence of):						į		
2 0 0	2		d									i		
Cords, P.O. Box v requires that the deeth cert been signed by the attending should be deteched for use	Physician/											1		
P.O.	ysi	Pert II. Other significant condition	contributing to d	leath but not resi	ulting in the u	nderlying ca	use giv	en in Part I			obacco use co			
P.O. that the ed by the deteche		niv N	(chun)	hally						1 Y	08 2 No	3 Probe	ibly 4□L	Jnknown
ords requires een sign hould be	d by	Anicano	, 1	1						24a. Was e	n autopsv	24b. Were	e eutopsy fir	ndings
pear y should should	ete	PINZVII								perfor		com	lable prior to pletion of ca sath?	nuse
of Vital Records, Physician: The law requires t this certificate has been signe ral director, page 2 should be	Completed	Civi P	etinitis								ু কীল্লা-		· Aus	S1-
f Vital Re ysician: The last certificate he director, page		25. Was case referred to medical	Ollaro					26 Dinas	ad Doo	1 Y		10	Yes 2001	-
of Vita Physician: this certific ral director,	To Be	examiner? 1 Yes 2 No	Hospitel:	Inpatient 2 🗆	ER/Outpatien	* 3□ DO	Oth	vine-		ith <i>(Check</i> on <i>ly or</i> lome 5 ☐ Resid		nar (Snacihi)		
Phys or this eral di		27. Manner of Death	28a. Date	of Injury	28b. Time of		Sc. Injur Wor		rong r	28d. Describe h				
often often	tio	1 Netural 5 Pending 2 Accident investige		nth, Day Year)	Injury	М		Yes 2□	No					
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Division or with the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely lilled in by the funeral	Certification:	4 □ Notificide	Dulid	ing, etc. (Specif)	7)					City or Tow	ii, State)			
Fo the Hospital Within 24 hours Fo the Funeral		29a. Certifier (Check only 10 Medical Ex	Physician: To the	best of my known	wledge, death	occurred e	t the tir	ne, date an	d place	, and due to the c	ause(s) and m	anner as stat	ied.	
the H lin 24 the Fi	edical	one)	caminer: On the b and men	ner stated.	HORI MINOZOF III	restigation,	m my o	pinion, oea	un occu	rred at the time, c	ate and piece,	and due to ti	ne cause(s)	
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(3)		30. Neme and address of person w	1/		23a) (Type,	Print)	RAT	170		one	41	to.	don N	10
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CEUT CHAMME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death January 12, 1999 **Physician** 11:07 AM Lawrence S. Rogers /Medical 4b. City, Town, or Location of Deeth 4a Fecility Nama (If not Institution, give street and number) 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1XXM 2□ F Months Days Yrs October 20, 1971 Washington, D.C. Director 578-92-8066 Usual Rasidence of Decedant with the Meryland 10a. Stata 10b. County City, Town or Location Washington 10d. Inside City Limits r 28a-f show XXYes 2 □ No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiena. Important: If them 27 is marked other than *--- any injury or other traumestant injury or other traumestant. I is marked other than "natural", or itema 23a or traumatic event, the Medical Examinar must be a 20032 U.S.A. 1210 SOuthern Avenue, S.E. Apt. #302 Funeral 12. Was Dacedant Ever in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, atc. 1 Tas 2 No If Yas, Giva Year or Detas: 1XX Navar Marriad 2 Married 1 ☐ Yas 2XXNo Specify: Specify: Black Py 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade complated) 16b Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Captain White Boat S.W. 10th grade Fishman 17. Fethar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be Louise Anderson Walter Rogers 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ratationship (Type, Print) 1210 SOuthern Avenue, S.E. Apt. #302 Wash. D.C. 20032 Mrs. Louise M. Bradshaw (Mother) 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Steta 20a. Mathod of Disposition Forest Hills Memorial Gardens 1/16/99 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 23a. Part1. Enter the discorning complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onsat end Daath **Physician** /Medical Immadiata Causa (Final disaase or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examiner PERITONITIS The law requires that the death certificate be axecuted physician and the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical thet initieted evants rasulting in daath) Last Dua to (or as a consequanca of) use as t signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TERMINA L 2 Immrede farency 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of cause of death? page 2 has certificate 1 Yes 2 No 1 ☐ Yas 2X No or Attending Physician: director. 25. Was casa rafarrad to medical exeminer? Be 26. Placa of Daath (Check only one) Hospital: Inpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: 28b. Tima of 28c. Injury et Work? 1 Natural 5 Panding 24 hours efter death. 1 Yas 2 No Invastigetion 2 Accidant 6 Could not be datarmined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify) filled in by 4 Homicide Hospital 29a. Certifiar 1 Certifying Physicfan: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar es statad 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, data end piece, and due to the ceuse(s) and manner stated. (Check only one) To the I 29b. Signeture and titla of certifian 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar VILLAM

31. Data filad (Month, Day, Year)

JAN 1 9 1999

30. Name and address of parson who complated causa of daath (Itam 23a) (Type, Print)

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HOCE

32 Ragistrar's Signatura

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Hosp Drive, Cheverly

of activity great area.

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Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Haalth and Meniel Hydens.
Important: If item 27 is marked other than "natural", or items 23s or 23s-1 show any injury or other traumatic event, the Hedical Eventual traumatic about.

Physician /Medical Examiner

Baitimore, Maryland 21215-0020

Physicia /Medic Examin

	Jr.	Plea	se Type or State of		nd / D		ent of I	lealth a		II Coples Mental Hy		_	ble.	1295	7
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d			sateague l					essup				lowar	rd		
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3	12 17. Father's Name	/Eiret Middle	I act)		MO	VING C	UNTRA	1	r'e Nan	ne (First, Middle		IVAT			_
	VAN G. 1									WILLIS		an Sumer	110)		
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	VAN G RO	ORTNSON	, SR. /Fa	ther	7	12 Cro	iccan	+ D100		S.E. Wa	ach	D C	20	010	
	20a. Method of Dis		, DR. /Fe	20b. I	Placa of	Disposition	(Name of			Date Date				Town, Stete	
			3 Removel from	State	cemetery	r, crematory	or other pla	ce)	į						
	4 Donation			GL	ENWC	OOD CE				1/23/99	Wa	shing	gton	, D.C.	
	21. Signature of E	II Service	last	М8	59	ALE:	XANDEI		OPE	FUNERA Avenue,			2002	1	
	23a. Part1. Enter) shock, or hea	he diseese, og rt feilure. List	complications that only one cause on	caused the deal	th. Do n							DC A	2002	Approximete Intervel Betw Onset and D	reen
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3	resulting in death)	Last		200 10 10	/ as a U	orisoquerica	oij.								
Liyalcialum			d						-	_			1		
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2														107	
Bosoldinoo					110	7				24a. Wes	s en eu omed?			Were autopsy file evailable prior to completion of ca of death?	
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-	27. Manner of Deat	h 5 🗆 Pendin	28a. Date (Mor	-	28b. T	ime of	28c. Inju	ry at		28d. Describe	how in	jury occu	med /	river	
Cura	242 Accident	investig	pation 01/	15/99	18	48 M		Yes 2 121	No	Auto -	Tru	M	100	43162	

sate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit To the Hospital or Attanding Physician: The law requires that the death carificate be associated within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the tuneral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Medical Certificat

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) JAN 1 9 1999

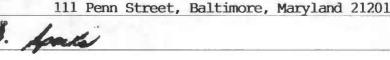
29b. Signature end title of certified

4 Homicide

29a. Certifier (Check only one)

6 Could not be determined

32. Registrar's Signature



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the cause of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 16, 1999

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Some S. Amoun

9981 0 1 11 Al.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 02958

			(or unoate	e of Death	· R	eg. No.	
	1. Decedent's Neme (First, Middle, Last	1)				2. Date of Deal Month		3. Time of De
nysician Medical	Donald Simpson	Rice				January	'	
xaminer	4e Facility Neme (If not institution, give	street end number)			4b. City, Town, or	Location of Death	4c. County o	f Death
	8803 48th Avenue				College	Park	Prince	e George's
neral	Social Security Number 6. Se		(In yrs. last birthe	day) If Under 1		8. Date of Birth		Birthplace (State or Fo Country)
ector	214-26-6812	XM 2□F	67 Yr	S. Wichtins	Days 110013 INI	March 1	9, 1931	Alabama
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ell ell	Maryland Prince G	eorge's	College	Park				1 ∑ Yes 2 [
be notified Director	10e. Street and Number			10f. Zip (Code	1	0g. Citizen of Wi	hat Country?
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ioner must be notified at Furneral Director	11. Meritel Stetus	12. Wes Decedent Ev- Armed Forces?	er in U,S.	13. Wes Decede	ent of Hispanic Origin? (fy Cuban, Mexican, Pue	Specify Yes or No-		- American Indien, White, etc.
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100		2	Mir	nister			Church c	of God
Be	17. Father's Name (First, Middle, Last)				18. Mother's Ne	me (First, Middle, I	Maiden Surname)
o de	Henry Rice				Phoebe	Simpson		
-	19a. tnforment's Neme/Retetionship (T)	ype, Print)	19b. N	Aeiling Address ((Street and Number or F	lural Route Number	, City or Town, S	itate, Zip Code)
5	Betty T. Rice - S	pouse	880	03 48th	Avenue, Col	llege Par	k, Maryl	and 20740
6	20a. Method of Disposition		20b. Plece of D	isposition (Nemo	e of	Dete	20c. Location - C	City or Town, State
5	1 ☑ Burlel 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)					11/25/99	Cheltenh	am, Marylan
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any	1 01				Address of Facility S Funeral I			
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 16, 1999 Letty Margaret Schafer Rockwell 10:00 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Magnolia Gardens Nursing Home Prince George's Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2⊠ F Yrs. 579-12-6461 78 Sept. 20, 1920 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or harms 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Prince George's College Park 10a. Street and Number 10f. Zio Code 10g. Citizen of What Country? 4901 Iroquois Street 20740 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give T Year or Dates: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Typist 12 Private permit. Pages 1 and 2 should be file.
Department of Heath and Mental Hy important: if them 27 is marked other any Injury or other treasurements of the statements. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) 89 Ephraim Schafer Cora Eva Beane 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) Rosemary Walters - Daughter 6843 Trexler Road, Lanham, Maryland 20706 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 MCremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 01/19/99 Alexandria, Virginia 22. Name and Address of Fecility
Gasch's Funeral Home, P.A. 21. Signature of Funerel Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 ersa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Final Intraceaebral 1 moult disease or condition resulting in death) Examiner Due to (or as a consequence of): Cardiovagular Discuse ARTERioslenotic the deeth certificate be executed pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Due to (or es a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Valvular Heart Disease by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? Candiac Annyihming 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate the Hospital or Attending Physicien: hin 24 hours after deeth. The Funerel Director: After this certific inpietely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation Netural 1 ☐ Yes 2 ☐ No 2 Accident NID 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ro the Hospital or within 24 hours To the Fur 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dale signed (Month, Day, Year) mea JANUARY 17, 1999 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 4203 QUEENSBURYRd HyGTTSVIlle, ND 20781 31. Date filed (Month, Day, Year) 432. Registrer's Signature

State Registrar

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

JAN 2 0 1999 **DHMH 16 Rev 6/95**

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 19, Nathaniel Renard Rushing 11:00 PM Jan /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton, MD Prince George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□ F Hours Months May 2, 1936 Director 577-44-5830 62 Wadesboro, NC Usual Residence of Decedent 10a. State 10b. Count 10c City Town or Location 10d. Inside City Limits 25a-f show 10/2/8 1 Yes 2 No Director Prince George Maryland Ft. Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ğ munt be Nems 23a 3617 Stonesboro Road 20744 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 1 1 1 1 2 2 1 1 No 7 / 1 5 / 60 If Yes, Give
Year or Dates: 6/30/66 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 21215-0020 natural, or 1 Yes ♥ No Specify: Specify: Black à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Supervisor U.S. Government 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be and 2 should be and Mental Alexander Rushing Savannah Chambers 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Wiggins / Daughter 6414 White Oak Ave., Camp Springs, MD Health important: If Item 27 any injury or other tr 20748 Pages 1 20b. Place of Disposition (Nama of cemetery, crematory or other p 20a. Method of Disposition Data 20c. Location - City or Town, State 6 or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery1/29/99 Cheltenham, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Pope Funeral Homes M00753 arr tommons 5538 Marlboro Pike, Forestville, MD 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Day to (or as a consequence of): Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): be axec Box 68760 Physician/Medical Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. been signed by ta should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, 2 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? moun 2 1 No 1 Yes 2 No certificate reed sume Division of Vital 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Data of tnjury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? After Attending 1 Natural 5 Panding Investigation death. 1 Yes 2 No 2 Accident or Attancation of the original distribution o 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signature and title of continue 29c. License number 29d Date signed (Month, Day, Year) hummer M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUC/20 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 22, 1999 0135 A Joseph Sura /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Harford Citizens Nursing Home Havre de Grace If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1⊠M 2□ F Days Hours June 23, 1922 Director 186-14-6040 76 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at Cecil Conowingo Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21918 United States 123 Log Cabin Lane Funeral death 12. Was Decedent Ever in U.S.
Armed Forces?

1 Mayes 2 D No.
If Yas, Give 1942-45
Year or Dates: 1952-54 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural", or iten any injury or other traumetic event, the Medical Examinat Black, White, etc. 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ➡ No Specity: Specify: þ White 3 Widowed 4 Divorced 1952-54 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Sergeant 1st Class U.S. Army 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stella Tomzak George Sura 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 123 Log Cabin Lane, Conowingo, MD Alice A. Sura/Wife 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20e. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State St. Mary's Cemetery 1/25/99 Pylesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Servica Licansee 22. Name end Address of Fecility Hicks Home for Funerals, P.A. 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or haert failure. List only one cause on each line. 21921 Approximate Intarval Batween Onset and Death Physician Malnulytion Delu 1 draluen 2 Mours /Medical Immediate Ceuse (Final disease or conditio resulting in death) Examiner Dua to (or as a consequanca of) Examiner the death certificate be executed physician and the burial-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that Initieted events resulting in death) Last Due to (or es e consaquence of): Box 68760, Physician/Medicai Due to (or as e consequence of): 88 usa Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? P.O. signed by to deline 1 Yas 2 No 3 Probably 4 Unknown oldale wikmson Division of Vital Records, þ 24b. Ware autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? has page 2 1 Yes 2 No 1 Yes 2 No cartificata 25. Was case raferrad to medical Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residenca 8 Other (Specify) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 10 Aftar this 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred Certification: 5 Pending 1 Divatural daath. 1 | Yes 2 No Investigation 2 Accidant after deatl Director: 6 ☐ Could not be datermined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide ò 24 hours a 1 Certifying Phyalofan: To tha best of my knowledga, death occurred et the time, date and pieca, and dua to tha causa(s) and manner as steted. 29a. Cartifier Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or Investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) end manner stated. within 2 29b. Signeture and title of confider 29c. License number 29d. Date signed (Month, Dey, Year) unau MID D 32609 1/22199 O+IVA 30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

Kammelin Muhau MD 703 Revolution st Harre De Grave MD 21078 32. Registrar's Signature State Registrar

JOHN JOSEPH SURA

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedenf's Name (First, Middle, Last) 2. Dafe of Death Month Physician Ruth M. Smith 1999 JANUAKY /Medical 4c. County of Death 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death / Examiner Rose Rosedale If Under 24 Hrs. 8. De SQUARE 6. Sex pilAl BATTIMONE FRANKlin HOS Cenle . Age (In yrs. last birthday) 8. Dele of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 63 Director 218-32-6731 Aug. Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 25s-f show other traumatic event, the Medical Examinar orant be notified at 1 X Yas 2 □ No Director Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21911 USA 12 Buckley Ave. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X) No If Yes, Give Yeer or Dates: 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stafus Bleck, White, etc. 1 Never Married 2 Merried "natural", or 1 Yes 2 No Specity: þ 3 Ø Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: if Item 27 is manked other than any Injury or other traumets. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker 12 Own Home 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip Henry Riley Mattye Ridinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy L. Smith/Son 124 Reynolds Ave. Rising Sun. MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Brookview Cemetery 1-22-99 Rising Sun, Maryland 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. 21. Signeture of Funerel Service Licensee, Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feiture. List only one gauge on each line. Approximate Intervet Between Onset and Death 23a. Part1. shock, **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 11 HOURS Examiner Due to (or as a consequence of) Examine ARd 10 MYODA attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): certificate be Physician/Medical Due to (or as a consequence of): 88 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Automathin 24 hours after death.

To the Funeral Director: After a few funeral bir for the fur 1 DeNatural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier

Division of Vital Records, P.O.

Box 68760

Baltimore, Maryland 21215-0020

Th

State

(Check only one)

29b. Signature end title of certifie

30. Name and address of person

MARCO

31. Date filed (Month, Day, Year)

areo

ZAMORA

completed cause of death (Item 23a) (Type, Print)

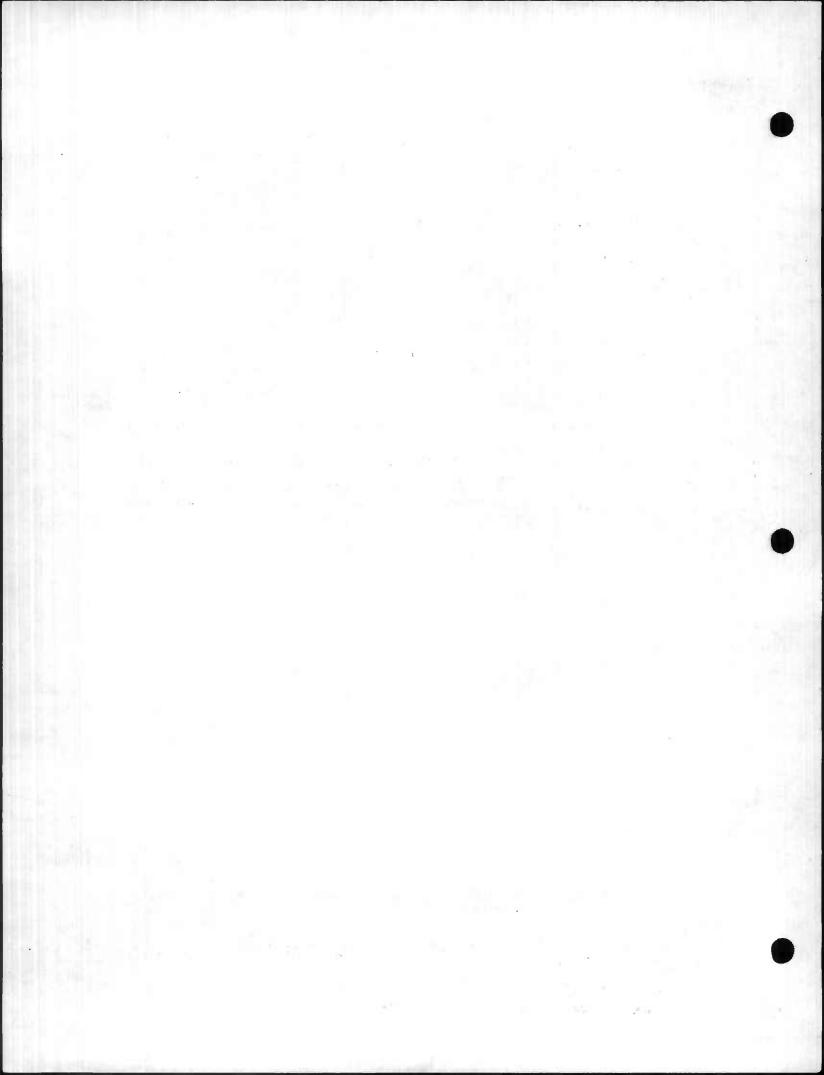
32. Registrar's Signature

FRANKlin

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29d. Date signed (Month. Day, Year)

Square Dr. Baltimons, Maryland 21237



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Nama (F		-25-99 c1		Och	tificate of l	Jealii	2. Data of Dea	leg. No.	3. Time of	Death
ician								Month	Dey Y	'eer	
dical	4a Fecility Name (If no		y Simmons			4	b. City, Town, or Lo	January	_	999 3:08 Death	PFI
niner	11100 1000 1000 1000 1000		s Hospita				Chever			George's	
al				. Age (In yrs. la	st birthday)	If Under 1 Year	If Undar 24 Hrs.	8. Date of Birtl	_	Birthpiaca (Stata or Country)	
or	5. Social Security Num 147-16-05 399-24-2 Usual Residence of De	202	1□M 2ÅF	78	Yrs.	Months Days	Hours Min.	July 3		New Jersey	
		0b. County		10c. City,	Town or Loc	ation				10d. Insida Cit	ly Limits
lor	Maryland	Prince	George's		Ca	apitol He	eights			1)X Yes	2 1 No
Funeral Director	10e. Street and Number	er				10f. Zip Coda			10g. Citizan of Who	at Country?	
2	5631 Sou	thern	Ave.			20	743		Unite	ed States	
5	11. Marital Status		_	lant Ever in U,S	. 13. W		ispanic Origin? (Sp n, Maxican, Puarto	ecify Yas or No-		American Indian,	11.00
-	1 ☐ Naver Married 3 ☑ Widowed 4 ☐			No No		Tas, specify Cuba ☐ Yas 2 ☐ No	Specify:	nican, etc.)	Specify:	Whita, atc. Black	
Be Completed	15	. Decedant's	Education grada complated)		16a. Deceda	ant's Usual Occup	ation	Ina	16b. Kind of Busin	nass/industry	
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			2			Homemake			Priva		
9	17. Fathar's Nama (Fin								Maiden Sumama)		
)		as E.						nnie Woo			
	19a, Informant's Name						and Number or Run				
			mons - So			ition (Name of	Ave., C	-)
	20a. Method of Disposi		☐Ramoval trom S	tata car	matary, cram	atory or other place	1	Data	20c. Location - Ci		
	4 Donation 5		20.11	Ar1			1 Cem. 1	/22/99	Arlingt	on, VA	
	21. Signatura of Funar	ral Sarvice Lic	census	0 -	22.	Nama and Addras		ewart Fu	meral Ho	ome	
	18/1	011	Sluga	11, 1		4001 Ber	nning Rd.	, N.E. V	Wash., D.		
	23a. Fall entar tha c	disaasa, or co ailura. List or	ily ona causa on aa	usad ind death. ch lina.	Do not anta	r tha moda of dyin	g, such as cardiac	or raspiratory ar	rast,	Approximate Intervel Bath	ween
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	Immediata Causa (Findisaasa or condition rasulting in daath)	ıaı	a	H Cel	10	Cowelle	gellee	8 no C	K	day	8
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	rasulting in daath) Last	t		Due to (or a	as e consequ	ence on:				0	
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	Part II. Other eignificer	nt conditions	contribution to do	th hut not recol	ting in the un-	dartying cause chi			-6		
170	ant in Other eigninice	conditions	Continuum to das	A POLITICATE SUIT	mig in the un		an In Part i	23h Di4 •		chute to the ceuse of	of death?
ı	0000	n. 0.	200-11	lead hat	44-4-	D	an In Part i.			ribute to the cause of B □ Probably 40%	
7	- 6022:	puln	ronay &	mbol	imy	Lever	an In Part i. re ayoter				Unknown
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State of Maryland / Department of Health and Mental Hygiene

hysician /Medical xaminer ineral ector	Hecto 4a Facility Name Pervice	ne (First, Middle, Las	SAUNDE					2. Dete of Dea		Yeer	. Time of Death
ineral rector	4a Facility Name	~		00				Month	Day 12		2:08 AM
neral ector	Prince ((If not institution, give					4b. City, Town, or	Location of Deeth			2.00 111
ctor			tosoital	Cent	~0		Cheverly		Pointe	e Geor	10015
tor	5. Social Security	Number 6 S	9x 7.		lest birthday)	If Under 1 Yo	ear If Under 24 Hrs		h		(Stete or Foreign
ector	578-07-381		QM 2□F	84	Yrs.	Months De	ys Hours Min	April 1		North Ca	
ector	Usual Residence	of Decedent 10b. County		10c Cit	y. Town or Loc	ation		,			Inside City Limits
ect	Mary land	Prince Geo	nrae ^{II} s		tol Heigh					100.	ty□ Yes 2□ No
	10e. Street end N		71 gc 3	Сирт	cor nergi	10f. Zip Cod	10		10g. Citizen of V	What Country	^
ā										That Country	
Funeral	7202 Hy	ton Street	12. Was Decede	nt Ever in U	S. 13. W	2074	O of Hispanic Origin? (Suban, Mexicen, Pue	Specify Yes or No-	U.S.A.	e - American	Indian,
		ried 2 Married	Armed Force					rto Ricen, etc.)		ck, White, etc.	
by	3 ☐ Widowed	4 Divorced	If Yes, Give Year or Deter			□Yes 2√□	No Specify:		Specify	Black	
Completed	(Spe	15. Decedent's Ed	ucetion de completed)		16e. Decede	ent's Usual Oc	cupation one during most of wo	orking	16b. Kind of Bu	usiness/Indus	lry
- du	Elementary/Sec		College (1-4d	or 5+)			one during most of wo tired)				
ပိ	8th Grade	(First, Middle, Last)			Trackma	an	18 Mother's Na	me (First, Middle,	Pennsylv		Iroad
Be C									Welder Samon	10)	
To	James S	Name/Relationship (7	vne Print)		19b. Mailing	Address (St	Unknow reet end Number or F		er. City or Town.	Stete. Zip Co	de)
			liece)				reet Capitol			20743	
	20e. Method of Di			20b. F	Place of Dispos	ition (Neme o	1	Date	20c. Location -		Stete
		☐ Cremation 3 ☐ 5 ☐ Other (Specify		10	-		ial Gardens	1/18/99	Clinton,	Marrylan	d
puce.	-	uneral Service Licen	-	101	22.	Neme end Ad	dress of Fecility		CT IIICOII,	rial y lai	u
DUCE	1/11	Zun A.	Ju	·			neral Home,		- D.C	00010	
	23a. Part1. Enter	the diseese, or comp art failure. List only o	licetions thet ceus	ed the deet	h. Do not ente	the mode of	Place, N.E. dylng, such es cerdie	ec or respiratory a	rest,	Ap	proximate erval Between
for use es the bunel-trensit	Sequentially list of any, leading to couse. Enter Und Cause (Disease of that initiated even resulting in deeth)	IS .	b	Due to (c	r as e consequ	ence of):	FARCTI	0 N			
Completed by Physician/M			d								
pieted by Physician/N	Pert II. Other sign	ificant conditions co	entributing to death	but not res	ulting In the un-	derlying ceuse	given in Pert I.	23b. Did	lobacco use co	ntribute to th	e cause of death?
Phy								1 🗆	Yes 2 No	3 Probab	ly 4 🛭 Unknow
by	777									T	
eted								24a. Was perfo	an autopsy rmed?	availa	autopsy findings ble prior to letion of cause
Compl										of dea	ith?
S	/							101	/es 2X3No	1 U Y	es 2K) No
Be G	25. Was cese refe examiner? 1 Yes		Hospitel:				Othor	eath (Check only o			
Ĕ.	27. Manner of Dec		28e. Dete of li		ER/Outpatient 28b. Time of		4 ☐ Nursing injury at Work?	Home 5 ☐ Resident 28d. Describe	dence 6 LIOth how injury occur		
tio	Natural 2 ☐ Accident	5 Pending investigation		Day Year)	Injury		Work? 1 ☐ Yes 2 ☐ No				
edicai Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	ZOE. PIECE UI	Injury - At he etc. (Specif	ome, farm, stre	et, factory, off	ice	28f. Location (: City or Ton	Street and Numb vn, State)	per or Rural R	oute Number,
dicai	29a. Certifier (Check only one)	1 D Certifying Phy 2 ☐ Medical Exam	reician: To the besis iner: On the besis end menner	of examine	wledge, death tion end/or inve	occurred at the	e time, dete and plac ny opinion, death occ	e, and due to the curred et the time,	cause(s) and made dete end piace,	anner as state end due to th	ed. e ceuse(s)
Medical Certification	29b. Signature an						ense number		29d. Date signe	d (Month, Da	y, Year)
1	1+	1-100K	46			D	40324		1/12/	99	
1	30. Name and evo	lress of person who d				rint)			+-+		
		A- JODRI	= M.D	30	al Llas	CIDA	DRIVE,	C Haras	14 40		

DHMH t6 Rev 6/95

Sunday

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth Day 5 1999 10:30 AM **Physician** JANLARY Margaret Ann Sparks /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Doctor's Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpieca (Steta or Foreign Country) **Funeral** 1 □ M 2 ☑ F 146-14-5037 Yrs. Director 75 Oct. 18, 1923 Pennsylvania Usuel Residence of Decedent 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ♥ Yas 2 No Director Maryland Prince George's 28a-f Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? iner must be n 22 Empire Place 20770 United States of America 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Dates: 11 Maritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bieck, Whita, atc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: À Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Nurse Healthcare/Hospital Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mothar's Neme (First, Middla, Meiden Surneme) Be 2 should be fi and Mental F Francis Rhoades Anna Fink 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) nt of Hsaith a : If item 27 is r or other tra John J. Sparks - Son 6655 Christy Acre Circle, Mount Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetary, crematory or other piece) 20c. Location - City or Town, Stete 1 N Burial 2 □ Cremetion 3 □ Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Spacify) Fort Lincoln Cemetery 01/19/99 Brentwood, Maryland 21. Signature of Fugeral Service Lice 22. Nama and Address of Facility Gasch's Funeral Home, P.A. 4/39 Baltimore Avenue, Hyats adions that course the death. Do not anter the mode of dying, such as cardiac or respiretory errest, 4739 Baltimore Avenue, Hyattsville, MD 20781 23e. Fx.rt1. Enter the disease, or shook or heart failure. List Onsat and Death **Physician** /Medical Immediete Ceuse (Finel aute Exacerbation Chronic Obstruction 3weeks disaasa or condition resulting in death) Examiner Pulateriuses Distuse Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disaase or injury that initiated evants resulting in daath) Last Dua to (or es e consequence of): Box 68760, Physician/Medicai the Due to (or as a consequenca of): USB 85 P.O. Pert Ii. Other significant conditions contributing to death but not rasulting in the undarlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? olywyalsia Rhea matica 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? page 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No Vital or Attending Physician: 25. Wes casa refarred to medical exeminer? Be 26. Pleca of Daath (Check only ona) Hospitel: 1 Pinpatlant 2 ER/Outpetiant 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 2 of 28e. Dete of Injury (Month, Dev Yaer) 27. Menner of Deeth 28b. Tima of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Naturel 5 Pending Investigation e Hospital or Attendin n 24 hours after deeth. e Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide in by t 28e. Place of injury - At homa, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physicien: To the best of my knowledga, deeth occurred at tha time, dete end plece, end due to the ceuse(s) end mannar as statad.
2 Medical Examiner: On tha basis of axamination end/or invastigation, in my opinion, daeth occurred at tha time, dete end plece, and due to the ceuse(s) end menner steted. Medical 29a, Certifier pletely (Check only one) within 2 the 29b. Signatura and title of certifiar 29c. Licansa number 29d. Date signed (Month, Dey, Year) loved Melite, our D17572 30. Neme and address of person who completed causa of deeth (Item 23e) (Type, Print) David Granite, MD 115 centerway Greenholt, MD 20770

filed (Month, Dey, Year)

IAN 2 17 1999 31. Dete filed (Month, Dey, Year) State JAN 2 0 1999 Registrar

DHMH 16 Rev 6/95

MARCARET



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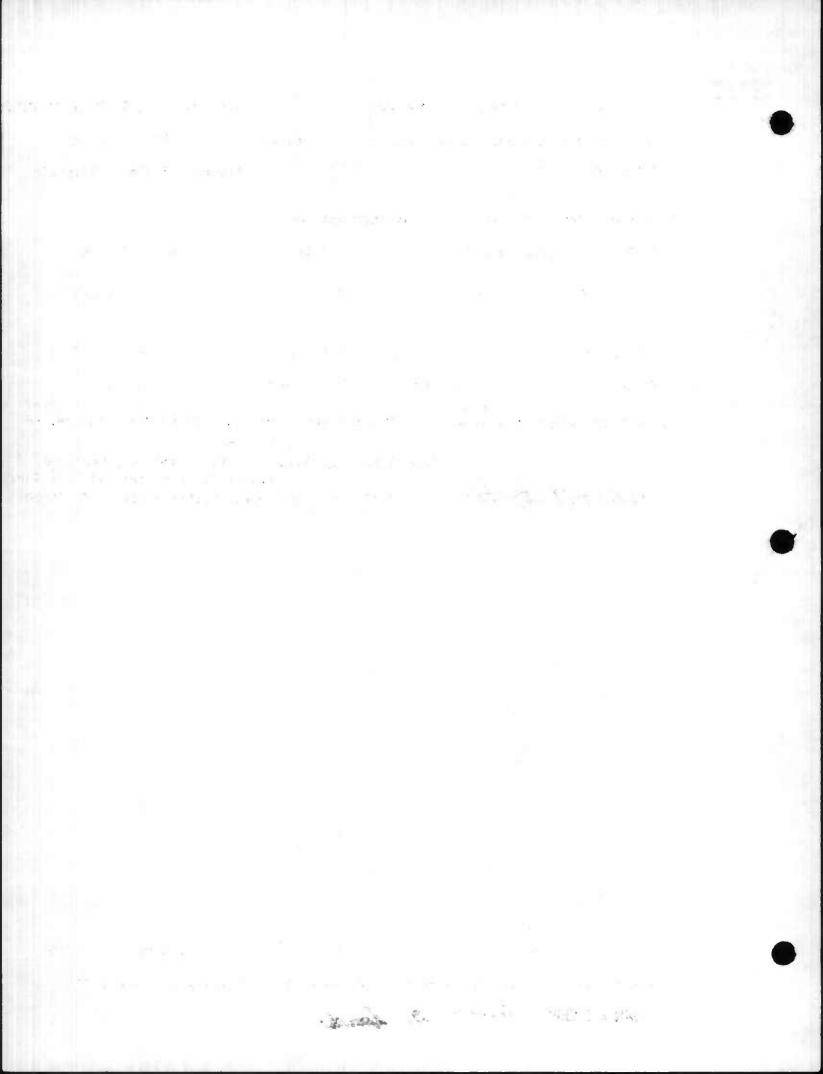
Physic /Medi		Decedant's Nama (First, Middla, L	ast)	Ochimoa	te of Death	2. Data of Dea	eg. No.	1	3. Tima of Death
/Medi	an			C1		_ Month	Day	Yaar	
		Walter 4a. Facility Nema (If not institution, go	Jerome	Saunders	4b. City, Town, or	January	16 ,		10:49 P.M
Exami	ner	Mariner Health		ruland	Clinto			ce Geo	roes
Funeral				lest birthday) If U	r 1 Y r If Undar 24 Hrs				e (Stata or Foreign
Director		230-50-5391 Usual Residence of Decedent 10a. State 10b. County	-	Yrs. Months	Days Hours Min.	Novembe	r 1,19	42 V	irginia
ef, or items 23a or 28a-f show Examiner inust be notified at	ector	Maryland Princ	e Georges	District				100	Inside City Limits
23a or 2 uat be n	Funeral Director	10e. Street end Number 1910 Wintergr	een Avenue	10f. Zi	20747	1	Og. Citizen of \ United		
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DHMH 16 Rev 6/95

JAN 2 1 1999

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Mary N. Schaake 99 18 :30 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death National Lutheran Home Rockville, MD Montgomery 5. Social Security Number if Under 1 Year If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1□M 2FF Days 214-74-8401 91 Yrs. 1/1/08 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 Veirs Drive 20850 USA 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: White 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker at home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Harry Mathaney Amelia Baumgartner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Nancy Hartman, daughter 7025 Hadlow Drive, Springfield, VA 22152 20b. Placa of Disposition (Neme of Oak Lawn Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 1/21/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Hysong 1300 N Company 1300 N Street, NW, Wash carons that aused the death. Do not enter the mode of dyling, such as cardiac or respiratory arrest, the page on each line. Washington, Approximate interval Between Onset and Death diseas Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably JUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 21 No 1 ☐ Yes 2 ☐ No 28. Piace of Death (Check only one) Other: 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Netural 1 ☐ Yes 2 ☐ No 2 D Accident

Physician /Medical Examiner The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral Director

Completed by

Be

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permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylei Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tra Maxical Example in unit be notified any pointe.

Baltimore, Maryland 21215-0020

with the Maryland

Physician/Medical à Be Completed 2 Certification: within 24 hours after death.
To the Funeral Director: A

signed by

After this

Attending

8

death

25.	Was case	referred	to	medical	
	examiner?				
	1 Yes	20 No			

27. Manner of Death

5 Pending Investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier /Check on

3 3 Suinida

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of

Name and address

pleted cause of death (item 23a) (Type, Print)

29d. Date signed (Month, Day, Year,

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

State Registrar

Medical

2. Registrar's Signature

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Mary K. Thomas January 8, 1999 7:58PM /Medicai 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Hospital Prince George's Lanham If Under 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** 8. Data of Birth (Month, Dey, Year) Birthpface (State or Foreign Country) 1□ M 3√ F 229-26-6658 88 Yrs. Director April 17, 1910 VIrginia Usual Residenca of Decedent 10a State 10b. County 10c. Cify, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at Mary land Prince George's Capital Heights 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? thems 23a or 515 Ashleaf Avenue 20743 U.S.A. 12. Was Decedanf Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ö 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Specify: Black 15. Decedenf's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 9th grade (0-12) College (1-4or 5+) Cafeteria Worker Prep. School marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surnama) Be 8 RObert Carter Mary Britt To 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) or other traur Mrs. Lena Hunter (Daughter) 515 Ashleaf Avenue Capital Heights, Maryland 20743 Pages 1. 20a. Method of Disposition 20b. Plece of Disposition (Neme of cematary, cremetory or other place) 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Ramoval from State National Harmony Memorial Park 1/15/99 Landover, Maryland 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee 22. Name and Addrass of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 or the mode of dying, such as cerdiac or respiratory arrest, . Enter the disease, or complications that caused the death. Do not enter the Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseasa or condition resulting in death) Examiner I Week Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury that Initiated events resulting in daath) Last Box 68760, Physician/Medicai Dua to (or as a consequence of): Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the undariying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? ata has been signed by page 2 should be detact farlise 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior fo completion of ceuse of death? 24e. Wes en autopsy performed? cartificata has 2 No 1 Yes 2 No or Attending Physician: Be 25. Was cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatienf 3 DOA After this 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Netural 5 Pending invastigation death. 1 Tas 2 No 2 Accident To the Hospital or Attended the Hours after death To the Funeral Director: 6 Could not be defermined 3 ☐ Sulcide in by t 28a. Place of Injury - At home, farm, sfraaf, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Medical 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and manner as stated. Halv 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) re Ava. Laurel, MD. 20707 30. Name and 31. Date filed (Mortif, Dey, Year) State JAN 1 9 1999 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Yeer **Physician** Norman Elbert Talley January 14, 1999 3:55 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1⊠M 2□ F Months Devs Yrs. 579-50-3597 59 May 27, 1939 Director Washington, DC Usual Residence of Decedent the Maryland 10d. Inside City Limite 10h Count 10c. City. Town or Location 1 Yes 2 No Directo Maryland | Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Heelih and Mentel Hygiene. Important: If fem 27 is marked other than "naturel", or items 23s or 2 and Injury or other traumatic event, the Medical Exempter must be marked. 4709 Longfellow Street 20737 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 No 1961— If Yes, Give Yeer or Dates: 1963 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Stelus Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bowling Alley 12 Mechanic 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) Mary Ellen Dawson Ocie Elbert Talley 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Mary Ellen Thompson - Sister 105 Jenkins Drive, Indian Head, Maryland 20640 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Buriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 01/18/99 Suitland, Maryland 21. Signature of Funeral Servica Licenses 22. Name end Address of Fecility Gasch's Funeral Home, P.A. | 4739 Baltimore Avenue, Hyatta 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximete fnterval Between Onset and Deeth Physician /Medical Immediete Cause (Finel disease or condition resulting in death) GASTRO INTESTINAL BIEEDING 1 047 Examiner Due to (or es e consequenca of): Examiner FailURR 1 044 LIVER To the Mospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. REMAI Failure Physician/Medical Due to (or as e consequenca of): MBUSE Alconol Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part fl. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evaileble prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 1 No 1 Yes 2 No Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Netural 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) end menner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier 0 38965 99 mules 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

Samuel E. Wilson, M.D., 3001 Hospital Drive, Cheverly, Maryland 32/Registrar's Signeture

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31. Date filed (Month, Dey, Year) JAN 2 0 1999

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	Malcolm							Camp	Spr	ings		ce George's		
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	Barbara D. Williams-Daughter 12002 Hickory Dr., Ft. Washington, MD										4D 2C)744		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland

Baltimore, Maryland 21215-0020

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Examiner	4e Fecility Name (If not institution St. Thomas Moor						4b. City, Town					orge's	
Funeral Director	5. Sociel Security Number 232–14–4892	6. Sex 1 X M 2 □ F	7. Age (In yrs. 69		Months	Pr 1 Year Deys		Min.	Date of Birti (Month, De)	Year)	9. Birthpl Count	ece (Stete or Fore	ign a
Test Test	Usuel Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or	Location						10	od. Inside City Lim	
al', or items 23a or 28a-f show Examiner must be notified at by Funeral Director	Maryland Prince	George's	Нуа	ttsvi		ip Code				10g. Citizen of	Whet Count	1 ∑ Yes 2 □ I	40
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eted	15. Decedent (Specify only highes			/Gi	cedent's Us	ork done	during most of	f working	,	16b. Kind of B	usiness/Ind	ustry	
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• •	John Oliver Un	derwood					Ethel	Sad	ie Hopl	kins			
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sician edical miner	23a. Fart Enter the disease, or shock, or heart failure. List Immediate Ceuse (Final disease or condition resulting in deeth)	only one cause on	Beps	th. Do not of	4739 1 enter the mo	Balti ode of dyir		venu	ie, Hya	ittsvill	Le, MI	Approximata Intervel Between Onset end Deeth	
by Physician/Medical Examine	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	c		or es e cons	sequence of								
hed for use as the state of the	Pert II. Other significant condition			sulting In the	underlying	cause giv	van in Part I.		23b. Did 1	obacco use co	entribute to	the cause of dea	th?
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this eldi	1 Naturel 5 Pendin	not be 28e. Place	a of Injury - At hing, atc. (Speci	iome, farm,		ory, office		28	of. Location (5 City or Tox		ber or Rura	l Route Number,	
T digi	1 Naturel 5 Pendin Investig 3 Sulcide 6 Could r datarm 29a. Cartifiar 1 Certifyin	g Physician: To the Examiner: On tha bend mer	ing, atc. (Speci	owledge, da	street, fectorath occurra	d at tha ti	ima, data and i	place, en	City or Towned due to the dat tha tima,	vn, Stata) cause(s) and m	annar es st and dua to	ated. tha ceuse(s)	

State Registrar

Elwin Bustos, M.D.
31. Date filed (Month, Dey, Year)

JAN 2 0 1999

1160 Varnum Street, N.E., Washington, DC 32. Registrer's Signeture

3A** . \$ 1935

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

To Be Completed by Funeral Director	Maryland 10e. Street end Numb 644 Applet 11. Marital Status 1 Never Married 3 Widowed 4	motinstitution, giver poital mber 6. S 17	e street end number ex 7. M 2 F	Age (In yrs. 64	lest birthday) Yrs. ty, Town or Location	if Under 1 \ Months D					1444 State or Foreign	
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	Anderson V	Viars					Margi	e Lawsor	1			
ē .	19a. Informant's Nam	ne/Relationship (Type, Print)		19b. Mailin	g Address (S	treet and Number or R	ural Route Numb	er, City or Town,	State, Zip Code)	
	Ruth R. V	iars/ Wi	fe		644 A	ppleto	n Road, El	kton, Ma	aryland	21921		
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edic	29a. Certifier 1 (Check only 2 one)	Cartifying Phy Medical Exam	ysician: To the bes iner: On the basis and manner	of examina	wledge, death tion and/or inve	occurred at the estigation, in	ed at the time, date and place, and dua to tha cause(s) and manner as stated. ion, in my opinion, daath occurred at the tima, data and place, and due to the cause(s)					
2	29b. Signature and titl	le of cartifier				29c. Li	cense number		29d. Date signed	d (Month, Dey, Y	'ear)	
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	71,00	s of person who	completed cause of	death /lten	- 00-) (*		1100		1 2	, -74		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Bessie E. Wright January 20 1999 15:15 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Laurelwood Care Center E1kton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1□ M 2☑ F Yrs. April 9, 1908 140-12-3618 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Maryland Cecil E1kt on 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Laurel Drive United States 21921 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Soup Canning Elementary/Secondary (0-12) College (1-4or 5+) 4 Supervisor Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Corbin Johnson Stella Rebecca Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy Jones / Niece 101 Marysville Road, North East, MD 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 23 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) North East Methodist Cem 1999 North East, Maryland 21. Signature of Fuseral Service Lices 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardionyopath MONTHS disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

Physician /Medical Examiner

The law requires that the deeth certificate be executed

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After

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Box 68760,

P.O.

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Division or Attending **Physician**

/Medical

Examiner

10a. State

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permit. Pages 1 and 2 should be filed within 72 hours after of Department of Healin and Mertals Hygiene. Department of Healin and Mertals Hygiene, exportants if them 27 is merted other than "natural", or the any injury or other trauments event, the Medical Examinat

Baltimore, Maryland 21215-0020

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Examiner physician and the buriel-transit Physician/Medicai signed by the at if be detached for P been si Completed page 2 8 Certification: To funeral filled in by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy tindings available prior to completion of cause of death? 1 Yes 20 No 1 Yes 2 PNo 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier MD

1717 Poog 1711

North Enit MD

January 21, 1999

21901

State Registrar

DHMH 16 Rev 6/95

Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Marksw

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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/Medi				VEAVER				JAN.	12,	1999	3:50 Al
Examir	ner	4a. Facility Name (If not institution, g				F	OCKV			4c. County of D MONTGC	MERY CO.
Funeral Director		220-50-1902	Sex 7. 1 □ M 2 🗓 F	Age (In yrs. last b	irthday) Yrs.	If Undar 1 Year Months Days	If Under Hours	Min. 8. Date (Month	of Birth th, Day, Yea 2, 1	903 F	Birthpiaca (State or Foreign Country) ENNSYLVAN
28a-f show	tor	Usual Residence of Decedant 10e. State 10b. County MONTG	OMERY CO	10c. City, Too		cafion CKVILLE	;				10d. Insida City Limits
3a or 28a at be not	Funeral Director	10e. Streef end Number 9701 - VEI	RS DRIVI	E		10f. Zip Code	850		10g. (Citizen of Whet	Country?
if of Heelth and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic event, the Medical Exercines instal be notified at	by	11. Marital Status 1 Never Married 2 Married 3X) Widowed 4 Divorced	12. Wes Decede Armed Force 1 Yas 2 If Yes, Giva Year or Date	es? XI No		Ves Dacedenf of I Yes, specify Cub		lgin? (Specify Yes n, Puarto Rican, et	or No- c.)		maricen Indien, /hife, afc. VHITE
Hygiene. ther than "nature ent, the Medical	Completed	15. Decedent's I (Specify only highest g	rade completed)		Deced (Give life. L	lent's Usual Occup kind of work done OO NOT use ratire	pation duning mos d)	t of working	16b.	Kind of Busina	ss/industry
end Mental Hygiene. s marked other than sumatic event, ma N		7 17. Fether's Name (First, Middle, Las	Coilege (1-4	or 5+)	OF	FICE CI		er's Nama (First, M			VAILABLE
Mentar mrked o	To Be	BYRD W. Mc					E	RNESTIN	E BE	SANZ	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
Heelth and am 27 is m ther traum		19a. Informent's Name/Relationship PATRICIA ALBRI	GHT- DAI	ND UGHTER-				TON DR.			e, Zip Code) LL • 20134
Department of Heelth of Important: If Itam 27 is any injury or other tra		20a. Method of Disposition X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Othar (Spec	□Ramovel from Sta	20b. Plece cemate	of Dispos ory, cren N P	sition (Name of natory or other pla ARK CEN	ce) 1 •	Dete 1/15/			or Town, State
Departi Importi any inj		21. Signature of Funeral Service Lice	ensee		22	Name and Addre HYSONO	co.	,INC.	сн	DC	
Nedical and physician and see st the burnel-transit	VMedical Examiner	Z3a. Part. Enter the disease of construction of heart failure. List only Immediata Causa (Final disease or condition rasulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter Undarlying Ceusa (Disease or Injury thet initieled avants resulting in death) Last	a. J	Due to (or as e	conseq conseq	uance of): Lystopic of): Cross		i'C (*CnCs)			Approximate Interval Between Onset and Death
gned by the atter be deteched for u	by Physician	Part II. Other significant conditions On Gostine At al A	contributing to death Contributing to death	th but not resulting	n fha ur	ideriying cause gir	en in Part I	+	Did tobacc	2□ No 3□	Probably Unknow
ate hes been si page 2 should I	Completed	Demondi	0		- 1	7/1001	201(3)		performed?		eveileble prior to complation of cause of death?
certificate rector, par		25. Was case referred to medical					00 DI	10 11 (0) 1	1 Yas	2□ No	1 Yas 2 No
	To Be	examiner?	Hospital:	atient 2 ER/O	utpatien	3□ DOA Oth	er: /	of Death (Check of Institute of Death (Check of Institute		6 □Other (S	inecity)
h. After thi funeral	ation: T	27. Manner of Deeth 1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L	njury 28b.	Tima of Injury	28c. Inju		28d. Desc		jury occurred	респу
is after death	Certification:	3 Suicide 6 Could not I determined	289. Piece of	Injury - At home, for etc. (Specify)	arm, stra	at, factory, office		28f. Locat City o	tion (Street a or Town, Sta	a <i>nd Number</i> or ite)	Rural Route Number,
within 24 hours after deati To the Funeral Director: completely filled in by the	edical	29a. Certifier	hyelcian: To the bes miner: On the basis end manner	of examinetion ar	e, death d/or Inv	occurred at the tirestigation, in my o	ne, deta an pinion, daa	d piace, end due to th occurred at the t	tha causa(time, dete a	(s) end menner nd place, end o	as stated. due to the ceuse(s)
To the	2	29b. Signature and title of conflict		cus		29c. Licans	a number	138	29d. D	pafa signed (Mo	onth, Day, Year) 7 12/1999
10)		30. Name and address of peraco who	Ja le	f deeth (Item 23a)	(Type, F	ring Addel	rout	RD, G	ечис	autour	y lub

Registrar

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2886 6 a . fue

1. Decedant's Nama (First, Middla, Last) 3 Time of Death Day **Physician** Cuilliams Gla 1999 SEOS dys 18 Jan /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Peath Examiner Spring Cross Srlves montromery NON 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours Yrs. Director 578-34-2774 New York Usual Rasidanca of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important of Health and Mental Hygiene. Important, if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examine must be notified. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Nas 2□ No Silver Spring MD Montgomery 10e, Street and Number 10f. Zip Coda 10g. Cifizen of What Country? U.S.A. 20904 1210 Downes Drive Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, White, atc. 1 Nevar Married 2 Married 21215-0020 1 Yas 2℃ No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedant's Education (Spacify only highast grada complated) 16e. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamantery/Secondary (0-12) College (1-4or 5+) Librarian Federal Government 10 Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Cora S. Sprague William C. Bell 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 1627 Nicholson Street, N.W. 19a. Informant's Name/Raletionship (Type, Print) Byron K. Williams Washington, D.C. 20011

20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Huntt Funeral Home, Inc./Cremat. 1/20/99 Waldorf, MD 21, Signature of Funaral Sarvice Licanse 22 Name and Addrass of Facility. Octoar Hill Funeral Home, Inc. 4111 Pennsylvania Ave., Suitland, shock, or heart in Ira. List only one cause on each line. 4111 Pennsylvania Ave., Suitland, MD 20746 Approximata Interval Batwean Onsat and Death **Physician** Immadiata Causa (Final disaasa or condition rasulting In daath) /Medicai Examiner Dua to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Sequantially list conditions, if any, laeding to immediata cause. Enter Underlying Causa (Disaase or Injury that initieted events rasulting in daath) Last and Dua to (or as a consequence of) Box 68760, physician Physician/Medicai the th Due to (or as a consequence of) signed by the attending I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed has certificate 1 ☐ Yas 2 ☐ No 1 Tas director, Be 25. Was casa refarred to medical exeminar? 26. Placa of Death (Check only one) Hospital: 1 Yas 2 No Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify) Certification: To 2XER/Outpatient 3 DOA 1 Inpatiant this 27. Mannar of Death funeral 28a. Date of injury (Month, Day Yaar) 28b. Tima of Injury 28d. Dascribe how Injury occurred 28c. Injury at Work? Affart 5 Panding invastigation death. 1 Yas 2 No 2 Accident after death Director: the 6 Could not be detarmined 3 Suicida 28a. Plece of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homloida 24 hours a Funeral D t Cartifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) and manner as stated.

Cartifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the ceuse(s) and manner as stated.

Cartifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the ceuse(s) and manner as stated.

Cartifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the ceuse(s) and manner as stated. Medicai 29a. Certifler (Check only

completaly To the To the I

30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)

IRR N. BRECHER, MO DME 31. Data filed (Month, Day, Yaar) State JAN 2 1 1999 Registrar

29b. Signatura and thia of certiflar

82. Ragistrar's Signatura

M M DIME

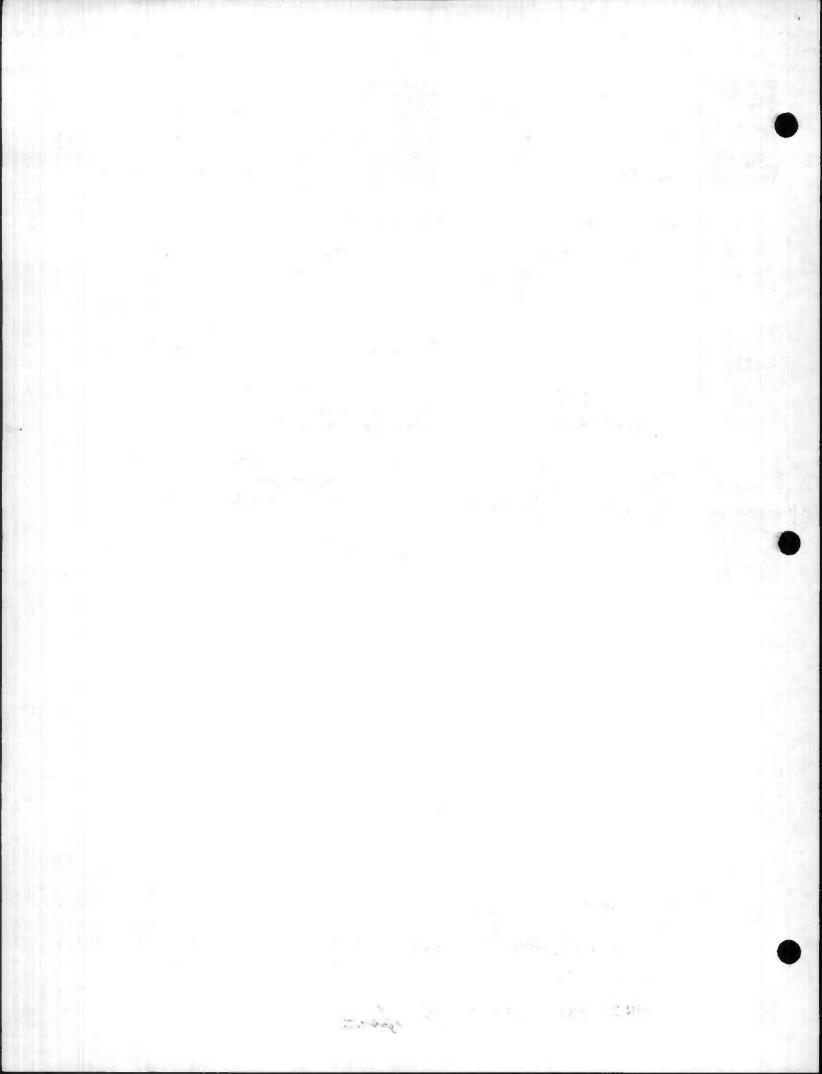
29c. Licansa number

1000428

Scluer Spring

2101 medical Park Dr

29d. Data signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene

					· Wai yiai		tificate of	Death	R	leg. No.	Ug	29/9
ı	Physicia	ın	Decedent's Name (First, Midd	tie, Last)	11				2. Dete of Dea Month	Dey	Year	3. Time of Death
7	/Medica	al	4a Facility Name (If not institution	VY	0/10)	b .		4b. City. Town, or L	JAN ocation of Death	4c. County o	4 Dooth	1.7011
d	Examine	er			noer)							
1	Funeral		HOLY CROSS 5. Social Security Number		7. Age (In yrs	. last birthday)	If Under 1 Year		8. Dete of Birth (Month, Dey	Montg		Y
L	Funeral Director		577 - 44 - 0659 Usual Residence of Decedent	1QM 2□ F	64	Yrs.	Months Days	Hours Min.	(Month, Dey 8 – 22 –			ce (State or Foreign Carolin
	Vanyland Vahow	0	Manyland Do	, inceGeord		orest					10d.	Inside City Limits
	the 1	Director	Maryland Pr	incedeorg	le i	01636	10f. Zip Code		T 1	l0g. Citizen of Wi	net Country	?
	ath with	ra D	1630 Forest				207			USA		
21215-0020	L. C.	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Giv	rces? 20 No		Was Decedent of F f Yes, specify Cub I□ Yes 2□xNo	lispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		- American , White, etc Blac	
5-0	72 ho	Completed		nt's Education est grade completed)		16a. Deced	lent's Usual Occup	pation during most of world)	kina	16b. Kind of Bus	iness/Indus	olry
121	rithin	d d	Elementary/Secondary (0-12)	1	-4or 5+)		DONOT use retire tractor	d)		Deli	verv	
	filled with Hygiens. ther than ant, the		12 17. Father's Name (First, Middle	f met)		COII	cractor	18. Mother's Nam	no /First Middle			
Maryland	SED A	Be									,	
7	should and Men arke umarke	10	Willie Wo	olley		10b Mailie	na Addrese (Ctena)	Julia and Number or Ru		ison City or Town S	tate Zin Co	ade)
Ma	d 2 sho th and 7 la m traum		Evelina Woll									
6	s 1 and M Health Itam 27 other tr	1	20a, Method of Disposition	rey-wire	20b.	Place of Dispo	sition (Name of	Park Di		20c. Location - C		
JOH TO	8 = 5		1 Burial 2 Cremation 4 Donation 5 Other (3 Removal from	State		natory or other pla		-23-99	Hvatte		o M.d.
altimore	artmer ortant: Injury	1	21. Signatuse of Funeral Service		П		/ Cemet	ery 1				
Ba	Dep Impo		Same a	u Mi	lan	4	ll Kenn	edy St,	V.W.,Wa	shingt	on,D	. C .
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	or complications that controls one cause on e	aused the dea ach line.	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory em	rest,	In	pproximete terval Between
	Physician /Medical		Immediate Cause (Finel disease or condition	M	VOCO	-dial	Infa-r	Lion				nset and Death
1	Examiner		resulting in death)			(or as a consec				Immedia Many		
-	D #	Examiner		- b - C	0-04	ary.	A-Yery	Diseas	e		1	Jany Yrs
	and I-tran	Xar	Sequentially list conditions, If any, leading to immediate									
60,	cata be axecuted physician and tha burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	G								
68760,	ficate be executed physicien and is the burief-transit	edical	that initiated events resulting in death) Last		Due to (or as a conseq	uence of):				1	
				d								
Box	death certification as attending of for use a	Clar							1			
0	e de	Physician/M	Part II. Other significant conditi									oly 4 Unknown
S, D	as that igned b	by P	Veriphera	Vascu	lar 1)	iseas	2,		101	es 2□No	3 Probet	xy 4⊌ Onknown
Records,	law requires that as been signed b	Completed	Periphera Multiple A	mputiti	015,	Renal	Failu	-e,	24a. Wes a perfor		availa	autopsy findings able prior to eletion of cause
	4 - 2	mo.	Anemia,	Deme	ntia.				10Y	es 20 No	1 🗆 Y	
of Vital	s certificata director, pag	Be	25. Was case referred to medical examiner?	le L				26. Place of Dea	th (Check only or	ne)		
=	Physician: this certific	2	1□ Yes 2☑ No	Hospital:	npatient 20	ER/Outpatier	3LF DUA		ome 5 ☐ Resid	ence 6 DOthe	(Specify)	
	5 5 5	0	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	ng 28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe h	ow injury occurre	d	
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Division	or Attending after death. Director: After in by the fune	Certification:		mined 288. Mace	of Injury - At I ng, etc. <i>(Spec</i>	nome, farm, str ify)	eet, fectory, office		City or Tow	treet end Numbe n, Stete)	r or Rural R	loute Number,
	pltal ura illed		Mr. Coules									
	Hos Fun Fun	edical	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the Examiner: On the be and mann	isis of examin.	ation and/or im	estigation, in my o	me, date and place opinion, death occu	, and due to the c rred et the time, c	ause(s) and man late and pleca, a	ner es state nd due to th	ed. le cause(s)
		ž	29b. Signature and alle of bentily	y	00		29c. Licens	se number	2	29d. Date signed	(Month, Da	y, Year)
	F 3 F 8) XII	- 17	7	~ ^	1	3100		./	10/-	~
	(1)	-	30. Name and address of person	who completely caus	of of down no	m 23el /Tune	Print) 7	3/00		Catr.	7/8	# 42 .
	(7)		Stuart	Turken	. /	con (19pe,	Gree	0 5-es	MAD.	2077		7-736
	State Registra		31. Date filed (Month, Day, Year JAN 2 2 199	9 Sen	egistrar's Sign	ature	1.					

James S. Lines

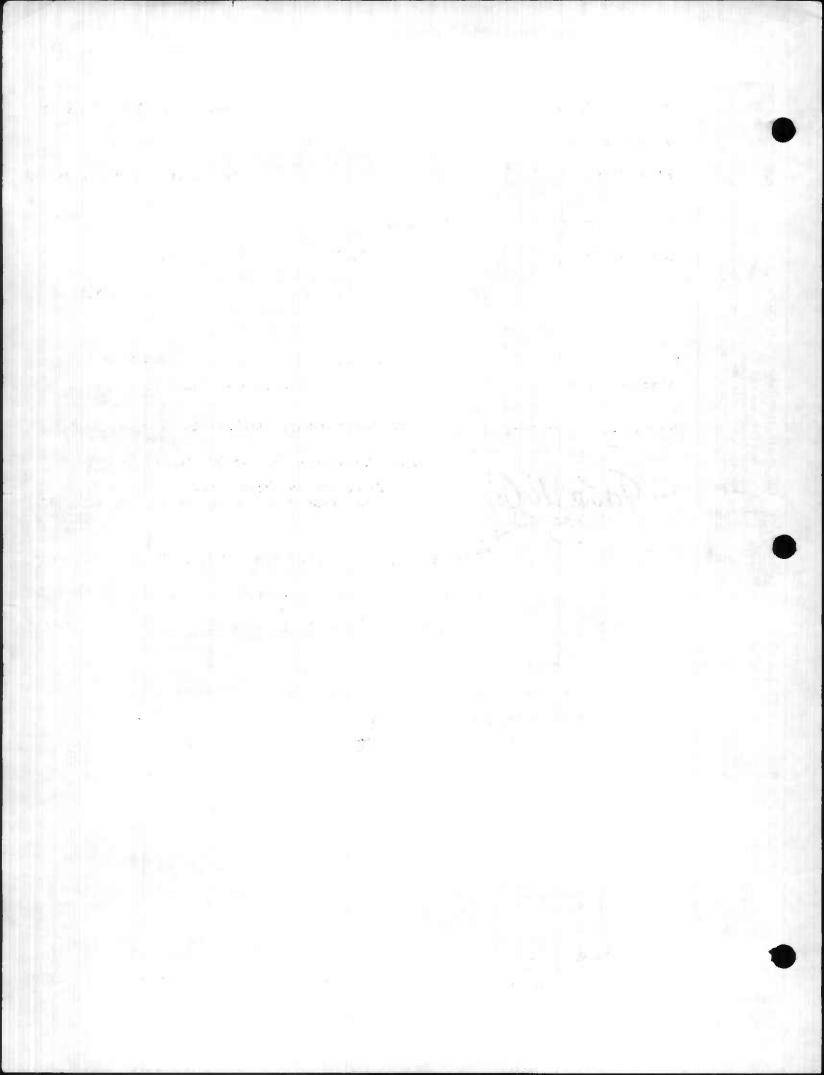
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State of Maryland / Department of Health and Mental Hygiene 9 02980

									Reg. No.			
	1. Decedent's Name (First, Midd	de, Last)						2. Date of De	eath Day	Year	3. Time of Dea	
hysician	Margaret J.	Ask						Februa		, 1999	3:00 p	
/Medical Examiner	4a Fecility Name (If not institution	on, give street and nu	mber)			4b. City, To	wn, or Lo	cation of Deat		County of Dea		
. Xaiiiiiiiii	7502 Laird's W	av				Clar	ksvi	11e		Howard		
marral .	5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.		8. Dete of Bi (Month, Di				
ineral rector	027-07-5790	1□ M 20XF	95		Months Days	Hours	Min.	Mar. 2	ay, Year)	9. Birthplace (State or For Country) Massachusetts		
•	Usual Residence of Decedent							rial . Z	, 1903	rias	Sachusett	
N III	10a. State 10b. Count	у	10c. City	y, Town or Lo	ocation						10d. Inside City Li	
d other than "naturel", or frame 23s or 28s-f show swent, the Medical Ensuring must be notified at Be Completed by Funeral Director	MD Howa	d	C1		:11.						1 ☐ Yes 2X	
be notified Director	10e. Street and Number	Lu	01	larksvi	10f, Zip Code				10a Citiza	en of What C	Country?	
											outiny:	
for must	7502 Laird's W	-		0 100	21029		1 1 0 10	-14 M	USA Yes or No- 14. Raca - American Indian,			
-	11. Marital Status	Armed Fo		,5. 13.	Was Decedent of I If Yes, specify Cub	an, Mexicai	n, Puerto	Rican, etc.)	0-	Black, Whi		
- X	1 Never Married 2 Ma	H Yes Gi	ve A		1□ Yes 2 No	Specify:			5	Specify:	White	
d by	3 N Widowed 4 □ Divorce	d Year or D	ates:									
rt, tre Medical I	15. Decede	nt's Education est grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during mos	most of working				s/Industry	
를 하	Elementary/Secondary (0-12)	College (life.	DO NOT use retire	d)	lost of working					
0	8	Ø		Hor	nemaker				Or	wn Hom	e	
Be Compl	17. Father's Neme (First, Middle	, Last)				18. Mothe	er's Name	e (First, Middle				
To E	Gaetano Ofria					Cath	erin	e Bella	amess:	ina		
-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address (Street	and Numb	er or Run	al Route Numb	per, City or	Town, State,	Zip Code)	
other treumatic				7500	Totadia	Llarr	01.		1 - M		1 21020	
the state of	Valerie A. Can	ada/Daught	20b. P	lace of Dispo	2 Laird's osition (Name of		Cla	Dete	20c. Loc	ary Lan	r Town, State	
-	1 ☐ Burial 2 🛣 Cremation		State	emetery, crei	matory or other pla							
any injury o	4 Donation 5 Other (Specify)	Ba1	timore	e Washing	ton C	r. 2	/5/99	Laur	el, Ma	ryland	
any in	21. Signature of Funeral Septice	(Dpensyle))	22	2. Name and Addre			. T				
Sing	4 John	Della Orl	0		Fleck Fu							
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	shool, or heart failure. Le	monty one series of	echline.								Approximate Interval Betwee Onset end Deat	
cian dical		- X						-				
Icai	Immediate Cause (Final disease or condition as SEVERE CONCESTIVE HEART FAILURE											
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	disease or condition resulting in death)	a		er as a consec		JE J	tene	T FAI	wel	Ξ	AYRE	
Je Je	disease or condition	^	Due to (o	er as a consec	quence of):					Ξ	4485	
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Je Je	disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	^	Due to (or Due to (or	STIVE	quence of):		nyo	PATH		ε	448	
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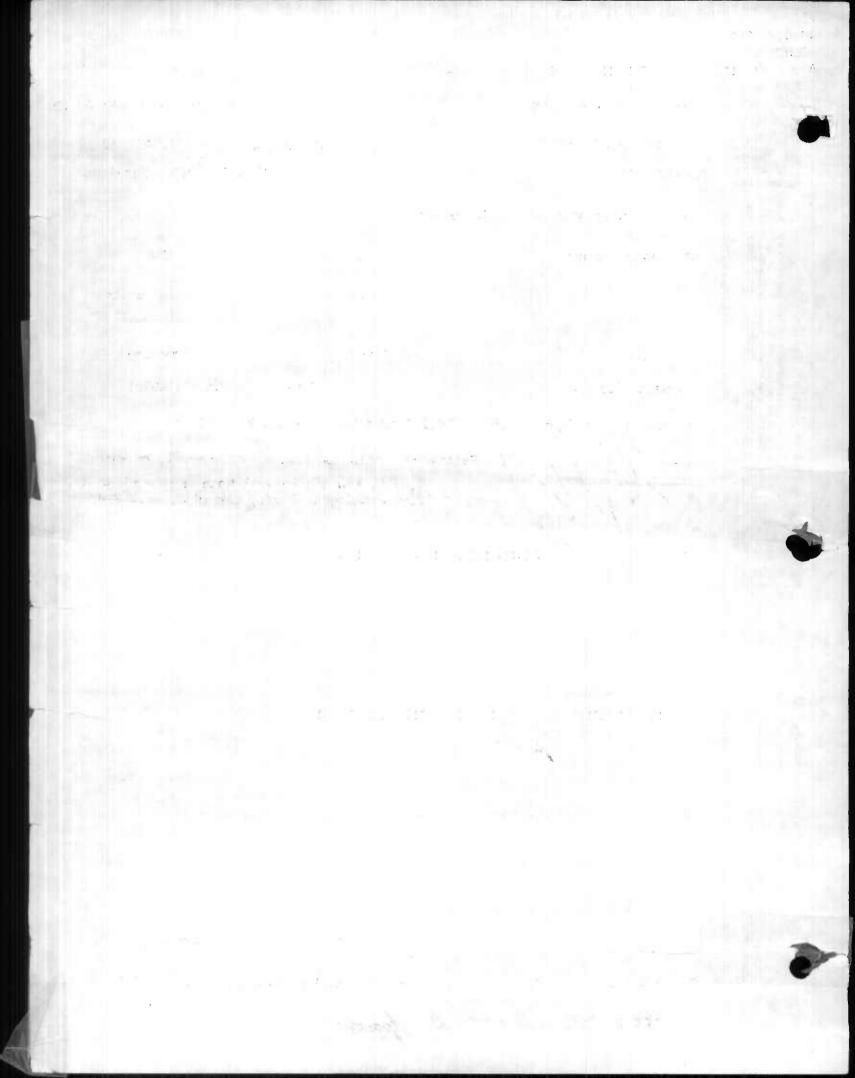
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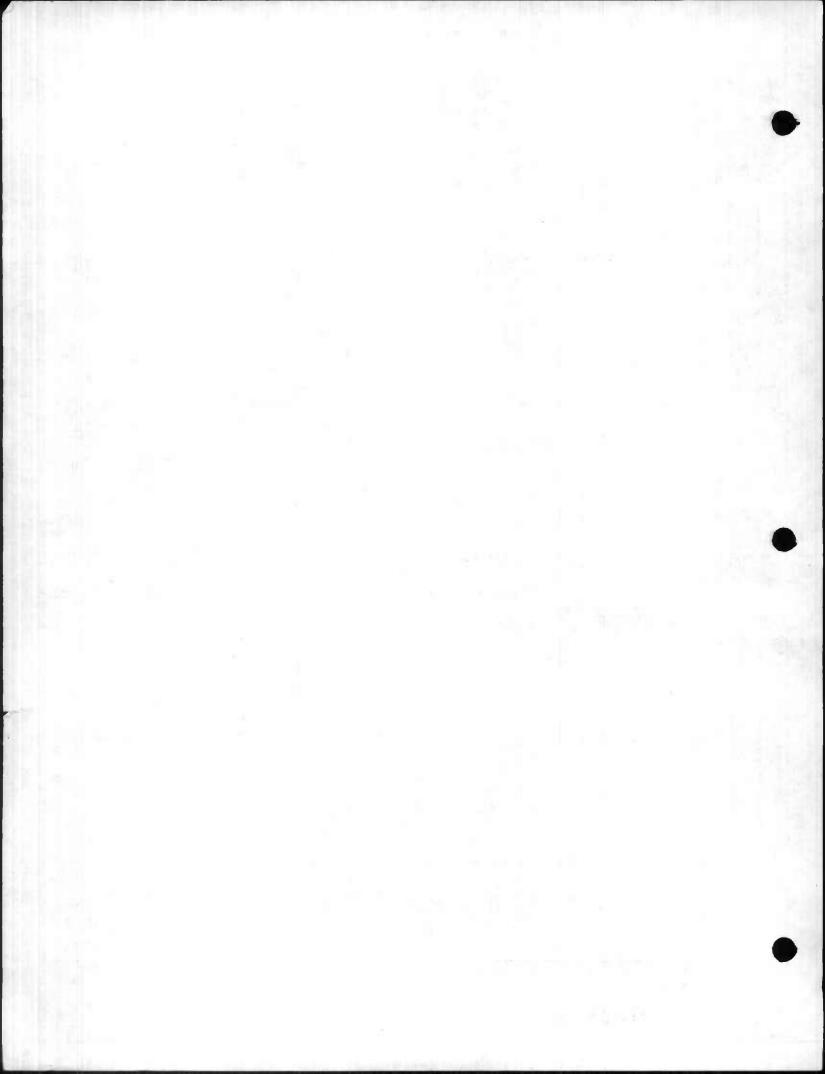


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Day Year **Physician** ANDERSON-COLLINS WBY M 02 1999 10:06PM **FEBRUARY** /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** NIA BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Deys 38 Yrs. 218-10-5091 MO Director Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Magical Examiner must be notified at 1 Yes 2 No NIA Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2915 WINCHESTER STREET 21211 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Deceden Evar in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Heelth end Mental Psystem Important: if item 27 is marked other than eny follury or other traumatic event, the Labbase. DAY CARE PROVIDER CHILD CARE YRS 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THELMA ANDERSON MUKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2915 WINCHESTER ST. BALTO. MO. 21216 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-8-99 RANDAUSTOWN KING MEMORIAL PARK 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO . on 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallium. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequenca of): Examine LMMUNOSUPRESSION physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 980 P.O. 23b. Did tobacco use contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy has 1 Yes 2 No 1 ☐ Yes certificate of Vitai or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA edical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending investigation 1 (BNatural s ster death.

I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital or within 24 hours sft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

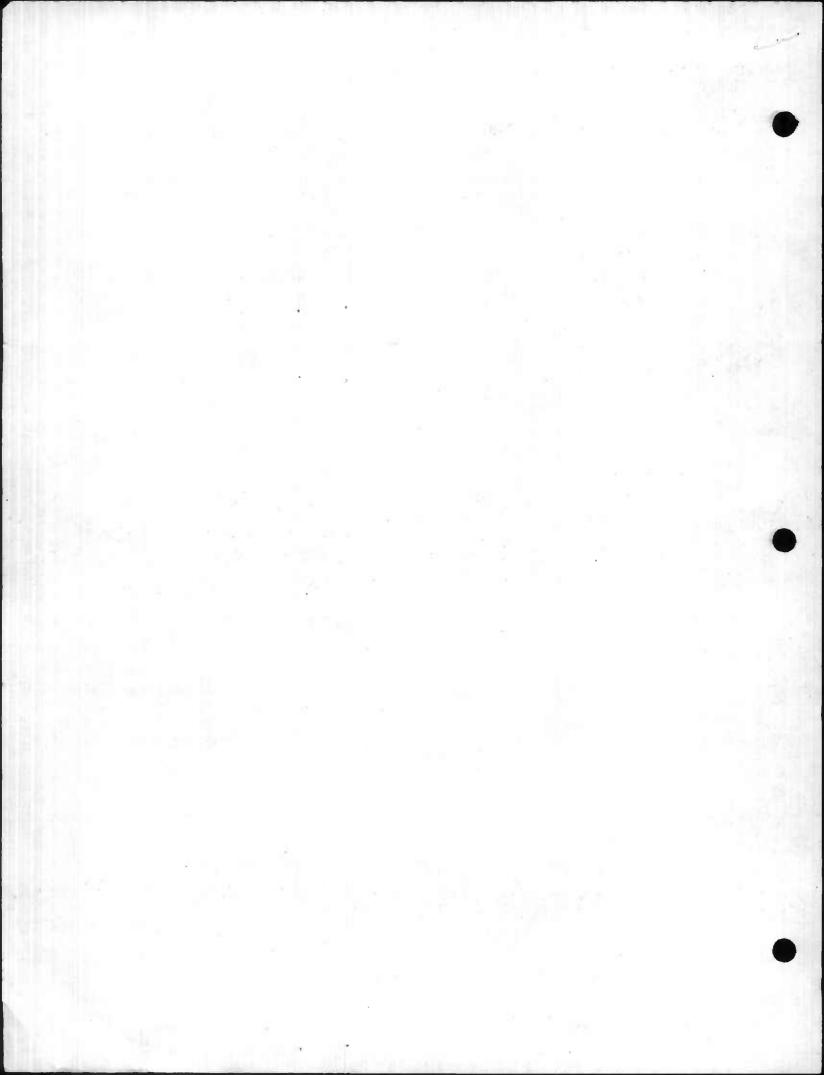
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatura and litle of certified 29c. License number 29d. Data signed (Month. Dav. Year) RES-DOO February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS KESPITAL GOD. N. Wolfe. STRUT BULLMORE, MD 21211 C. EVANS an. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 5 1999 Registrar



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ITEM: #1	LOD PER F.H G768 2-5-99 WR.	Certificate of Death	Reg. No.	12303						
Dhysisian	Decedent's Nama (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death						
Physician /Medical	Lulabelle Burson		Jan 27 1999	11:10 AM						
Examiner	4a Fecility Neme (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Silver S								
Funeral Director	5. Social Security Number 225-09-8852 Usual Residence of Decedent		(Month, Day, Year)	irthplace (State or Foreign Country) irginia						
Page 8 m		y, Town or Location		10d. Inside City Limits						
Mary Med and and other	Maryland Montgomery S	ilver Spring		1 Ves 2 No						
th with the Ma 23e or 28e-1 aust be notified all Director	10e. Street and Number 2700 Baker Street	10f. Zip Code 20910	10g. Citizen of What C USA	Country?						
un after des af, or lisers Examiner m by Funer	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No HYes Give Yaer or Datas:	.S. 13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☒ No Specify:		nerican Indien, nite, etc. lhite						
Z1Z13-UUZU ed within 72 hours al regions are than "natural", or set than "natural", or f. the Medical Exam Completed by I	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Cotlege (1-4or 5+)	16a. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired) Sales Clerk	nking 16b. Kind of Busines Departmen							
yland y wid be filed Mental Hyg whed other affic event.	17. Fether's Neme (First, Middle, Last)		ne (First, Middle, Maiden Sumeme) Virginia Mason							
and 2 sho saith and 127 is m ar traum	19a. Informent's Neme/Reletionship (Type, Print) Robert S. Ryan	19b. Meiting Address (Street and Number or Ri 340 Fair Lane - Win		, Zip Code) 22603						
altimore mit. Pages 1 partment of Na portant. If Nan y Injury or oth	20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)	Plece of Disposition (Name of Jemetery, cremetory or other plece) t. Hebron Cemetery	1/29/99 Vinchest	er, Virginia						
Demit. Depart Import any inj ance.	21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Jones Funeral Home 228 S. Pleasant Valley RdWinches									
death certificate be secuted death certificate be secuted a for use as the burial-transit af for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Ceuse (Diseese or Injury that initieled events resulting in death) Lest	ATORY FAILU or as a consequence of): STIVE HEAR! or as a consequence of): OMEGALY or es e consequence of):	IRE FAILURE	Onsel and Death 10 days						
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has been be 2 show			performed?	b. Were eutopsy findings available prior to completion of cause of death?						
= F ad O	25. Wes casa reterred to medical	26 Piece of De	1 ☐ Yes 2 ☐ No eth (Check only one)	1 Yes 2 No						
	examiner?	Other	Nome 5 Residence 6 Other (Sc	pecify)						
Attending Physic death. ector: After this by the funeral diffication: To	27. Menner of Death 1. Neturel 5 Pending (Month, Dey Year) 2 Accident Investigation	28b. Time of Injury at Work? M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	10						
tal or Attending P rs after death. al Director: After t led in by the funer Certification:	3 Suicide 4 Homloide 6 Could not be determined 28e. Plece of Injury - At h building, etc. (Specification)	ome, term, street, fectory, office	28f. Location (Street and Number or City or Town, Stete)	Rural Route Number,						
To the Hospital or Attending In the Hospital or Attending In the Funneral Director: After completely filled in by the fune Medical Certification	29e. Certifier (Check only one) Certifying Physician: To the best of my kno one) Medicat Examiner: On the basis of examine and menner steted.	wledge, deeth occurred at the time, date and place tion and/or Investigation, in my opinion, death occu	, and due to the cause(s) and manner irred et the time, date end place, and d	as stated. ue to the cause(a)						
To the To the comp	29b. Signeture end title of cadifier Merlyn K Vely	29c. License number 29c. License number	29d. Dete signed (Mo Jan 28 199							
	30. Name and address of person who completed cause of deeth (Item Merlyn K Vemury MD 9801 Geo	n 23a) (Type Frint) orgia Ave Silver Spring	Md 20902	A. A. V.						
State Registrar	31. Dete tiled (Month, Dey, Year) September 1999 32. Registrar's Signer 1999	ve G. Sparle								
DHMH 16 Ray 6/95	FEB 0 1303	N. Pouls								

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. ITEM: #12 PER F.H. G768 State of Maryland / Department of Health and Mental Hygiene Items: 28a,c,e per M.D G-768 2/5/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CAROL BROWN LEE 18, 1999 4c. County of Death /Medical January 12:30AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 5 Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Year 9. Birthplace (State or Foreign **Funeral** Hours Months Days N 2□ F 48 Yrs 7, 1950 MULLINS, SC 248-90-1534 Director AUGUST Usual Residence of Decedent filed within 72 hours efter deeth with the Maryland Hygiene. 10a. Stata 10c. City, Town or Location 10d. Insida City Limits r 28a-f show 10b. County 1 X Yes 2 □ No COLMAR MANOR Maryland Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 3712 41st AVE. 20722 USA Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. 1 X) Yas ZXINO 1970 -1☑ Navar Marriad 2☐ Married 1 ☐ Yes 21 No Specify. BLACK by Specify: 3 Widowed 4 Divorced Year or Dates: 1973 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COMMUNICATIONS SPECIALIST FED. GOVT. 12th event, II 18. Mother's Name (First, Middla, Maiden Surname) 17. Father's Name (First, Middla, Last) Peges 1 and 2 should be nent of Health and Mental Int. If Item 27 is marked or LILLIE MAE McMILLAN LEE BROWN 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Coda) nt of Health end: If item 27 is n CAMP SPRINGS, MD 20748 7338 TEMPLE HILLS RD. MARY EBRON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cremation 3 Removal from State permit. Pege Department of important: If any injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEM. 1-27-99 CHELTENHAM, MD 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD SUITLAND, 4308 SUITLAND RD. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the death, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Examiner Dua to (or as a consequence of) Physician/Medical Examiner physician end the burief-transit Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): nding pl Part II. Other afgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 42 Unknown þ 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed certificate hes b director, page 2 st 2 X No 25. Was case referred to medicel axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding Investigation Natural 28e. Place of Injury - Al homa, farm, street, factory, office building, atc. (Specify) deeth. 1 ☐ Yes 2 Accidant efter deeti Director: 6 Could not be determined 3 Suicida Location (Streat and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida none 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) To the To the To the I 29b. Signature and title of certifie 29c. License number 29d. Date signad (Month, Day, Year)

State Registrar 30. Name and addrass of person who completed cause of death (Item 23a), (Type, Print),

MLMas

31. Date filed (Month, Day, Year)

FEB 5

Prince George's Hos

32. Registrar's Signature

Baltimore, Maryland 21215-0020

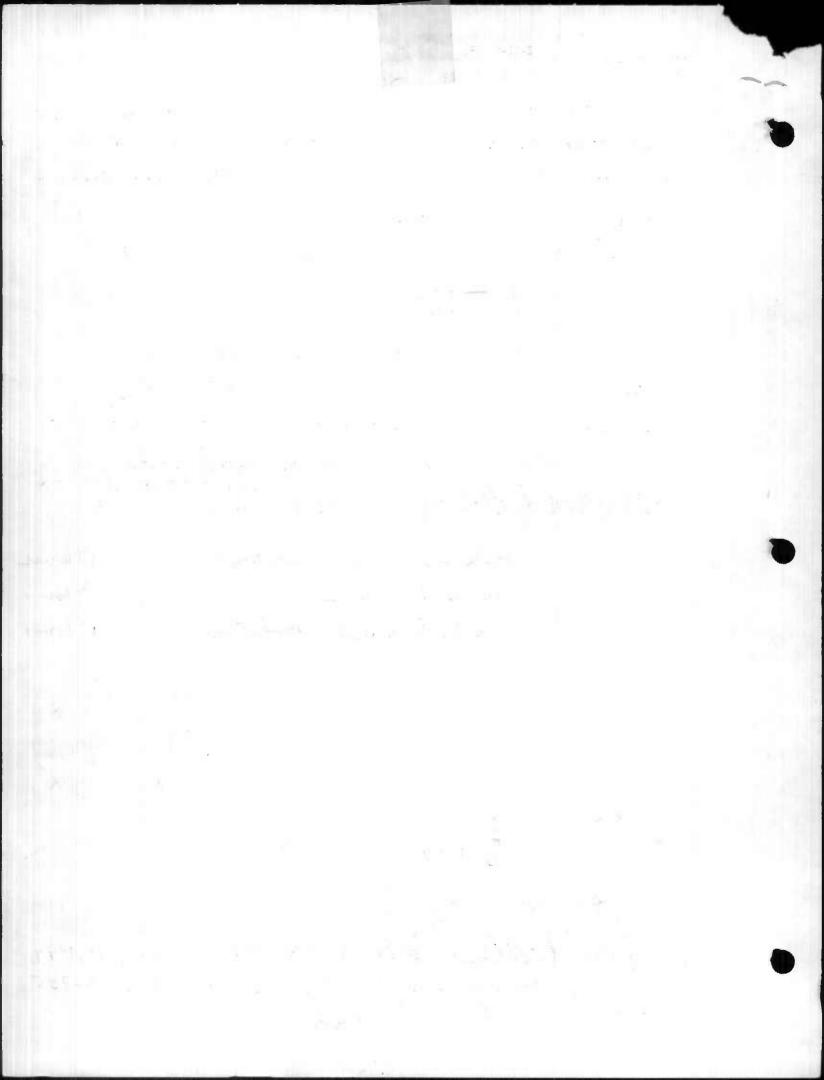
the death certificete be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

Hospital



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Bruce Block 1999 02:02 Flbruary 4 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death MORE Baltimore Veterans Hospital If Under 1 Year If Under 24 Hrs. 8. Defe of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 10 M 2□ F Months Hours 056-20-2884 May 17, 1927 New York Usual Residence of Decedent 10a. Stafe 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 Wardour Drive 21401 USA Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marifal Status 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1945-48 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sailing Sailor 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Melden Sumeme) Julius Block Anna Rothenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7 Wardour Drive Brian Newton/Friend Annapolis, MD 21401 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, State 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/04/99 | Baltimore, MD 21. Signaturo de Funerai Service License Lluar A. Gregorchik Edward A. Gregorchik 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, 21228 MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Lasf Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Pulmonar chronic Obstructive Rusease 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hypotension 2 No 1 Yes 2 No 1 Yes 26. Plece of Deeth (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

end The law requires that the death certificate be executed ettending physician effor use as the buriel-Box 68760. Physician/Medical signed by the e Records, been signated has e 2 After this certificate har Division of Vital Physician: or Attending death. Director: A

Physician

/Medical

Examiner

Funeral

Director

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Certification:

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25. Wes cese referred to medical

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

GREENE

29b. Signeture end fitle of certifier

29c. License number

29d. Defe signed (Month, Dey, Year)

STREET

2/4/99

30. Neme and address of perso, who completed ceuse of death (Item 23a) (Type, Print) COOTAUCO

31. Date filed (Month, Day, Year)

FEB 0 5 1999

EMILY

32, Registrar's Signature

resident

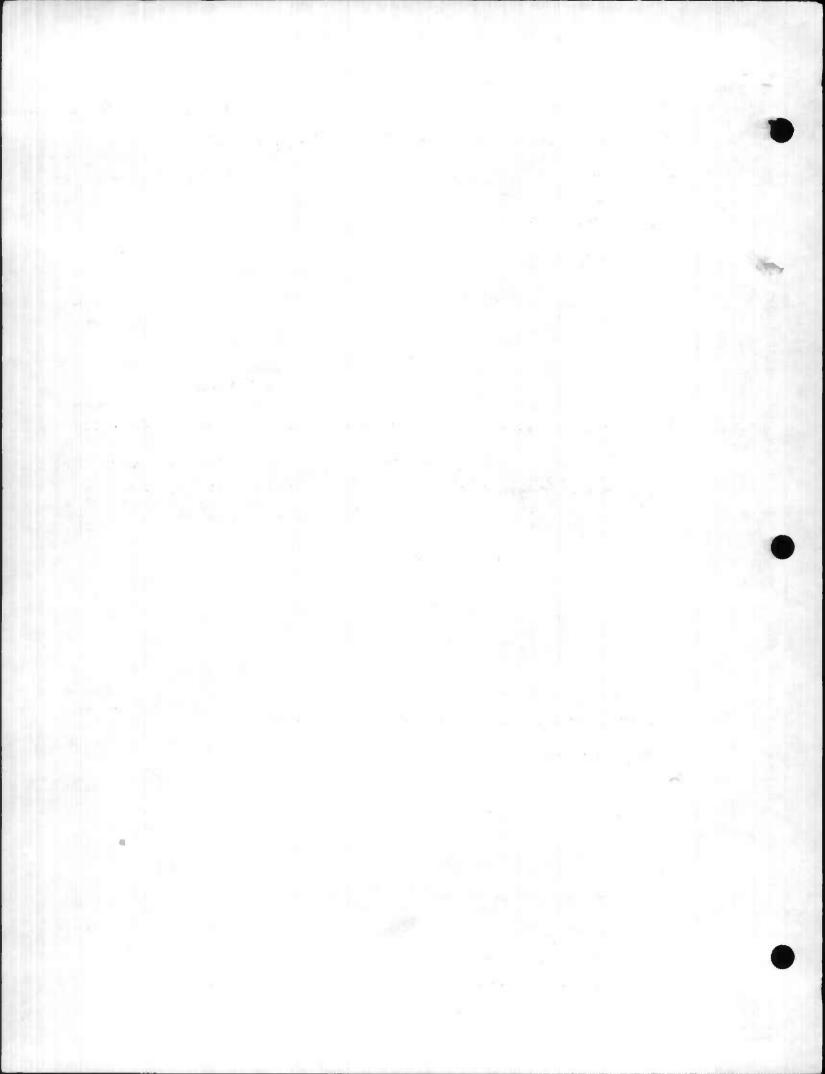
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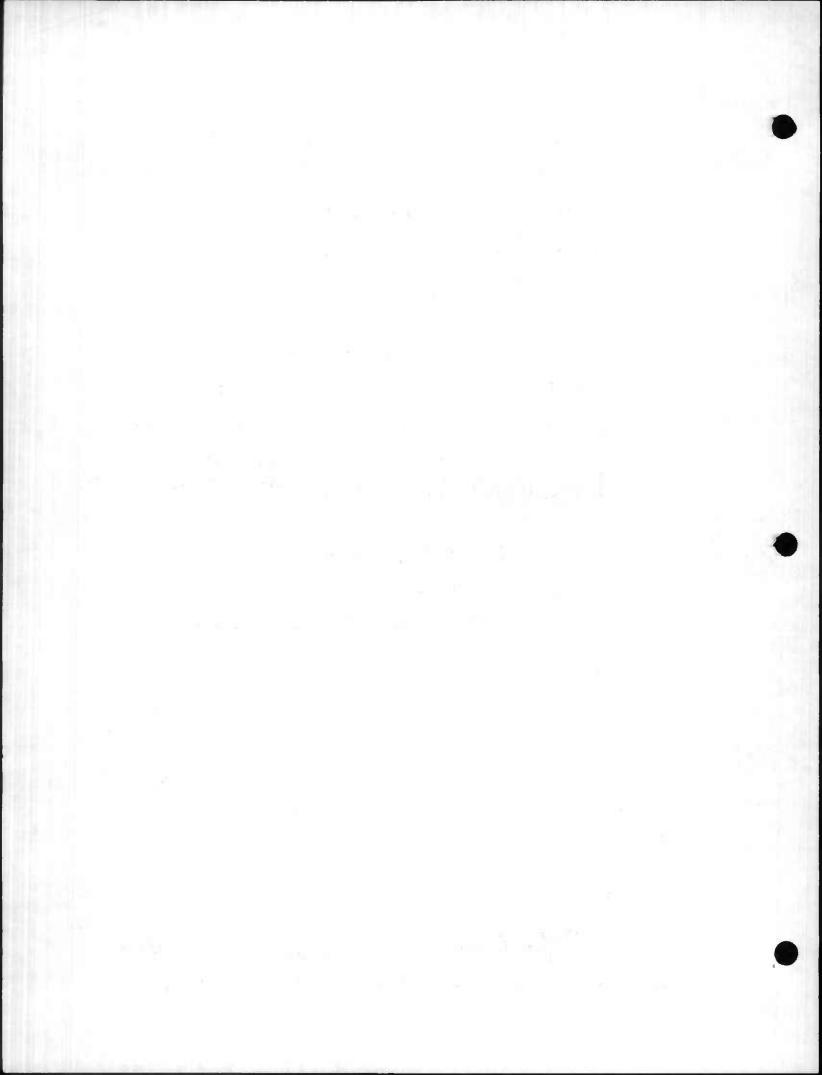
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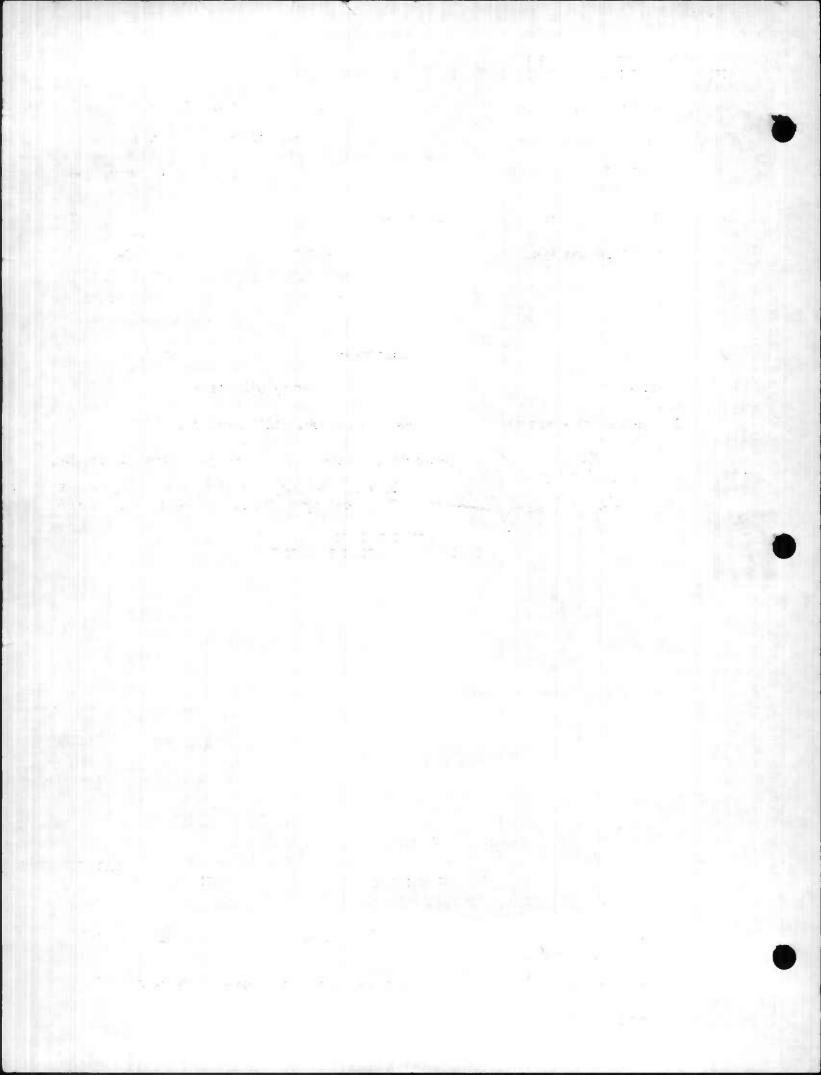
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Baltimore,	Department Composition of Indian Composition		21. Signature of Funday Service Long	4	000.	Ga	Name and	d Addre	ufman	Fun	eral Ho	me @ Mea	adowr	idge l	MP, Inc
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			30. Name and address of person who d	completed cause of o	death (Item	23e) (Type,	Print)				1 - 0 1				-
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State Registrar



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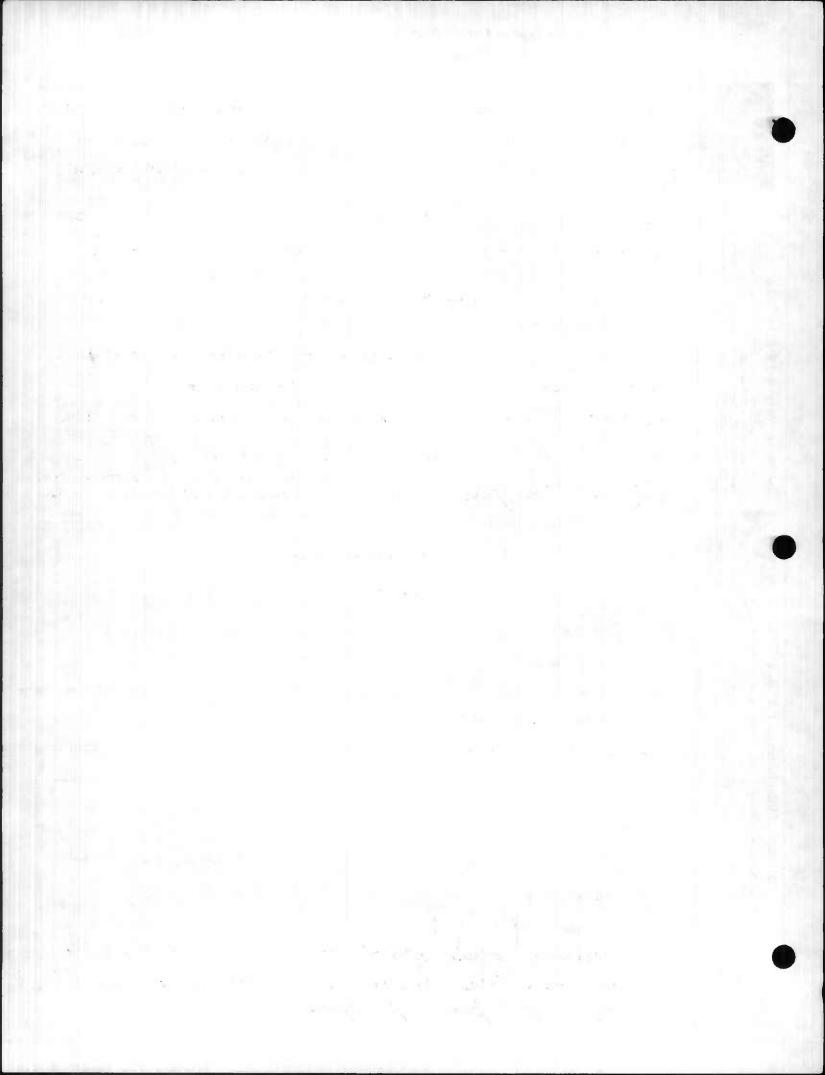
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death **Physician** 19 1999 3:00 A.M. Garrison W. Boykin January /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4s Facility Name (If not institution, giva street end number) Examiner Mariner of Kensington Montgomery Kensington 8. Date of Birth Month, Day, Year 28 If Under 24 Hrs. 5. Social Security Number 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Deys **X**M 2□ F Months Hours Virginia 71 Yrs. 231-26-4487 Director Usual Residence of Deceden with the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinal must be notified at ty Yas 2 No Director D.C. Washington 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of Whet Counfry? 7530 Eastern Avenue, N.W. 20011 United States permit. Pages I and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. I important: If Item 27 is marked other than "natural", or Items 23a and Injury or other traumatic event, the Medical Experimental ROBE. Funeral 14. Race - Amarican Indien. 12. Was Dacedenf Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, atc. 1 ∑ Yes 2 □ No If Yes, Give 1946-1949 Yeer or Detes: 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) Civil Engineering Technician | U.S. Coast Guard 12 18. Mother'e Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Kanora Wiggins Walter P. Boykin 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Burtonsville, Md. 3634 Alpen Green Way Kerri Boykin-Daughter 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Boykin Cemetery 1/25/99 Suffolk, Virginia 21. Signature of Funerel Sarvice Licensi 22. Name end Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Pert1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrasf, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onsef and Deeth **Physician** /Medical Immediete Ceuse (Finel disaase or condition resulting in daath) Metastatic Bladder Cancer Examiner Due to (or es e consequence of): Examiner Prostate Cancer 13 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760. physician The law requires that the death certificate be Physician/Medicai Due to (or es e consequence of): use as attending p signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Left Lower Lobe Pneumonia by 24b. Were autopsy findings aveileble prior to should 24e. Wes en eutopsy Completed been s Chronic Urinary Tract Infection completion of cause of death? page 2 s has 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury et Work? After or Attending 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 24 hours after death Funeral Director: 6 Could not be 3 ☐ Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide filled in Hospital edical 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Fune completaly fi (Check only one) end menner stated. 29d. Date signad (Month, Day, Year) 29b. Signatura and Itila of certifiar 29c. Licansa number 30. Name and address of person who completed cause of death (flem 23) (Type, Print)

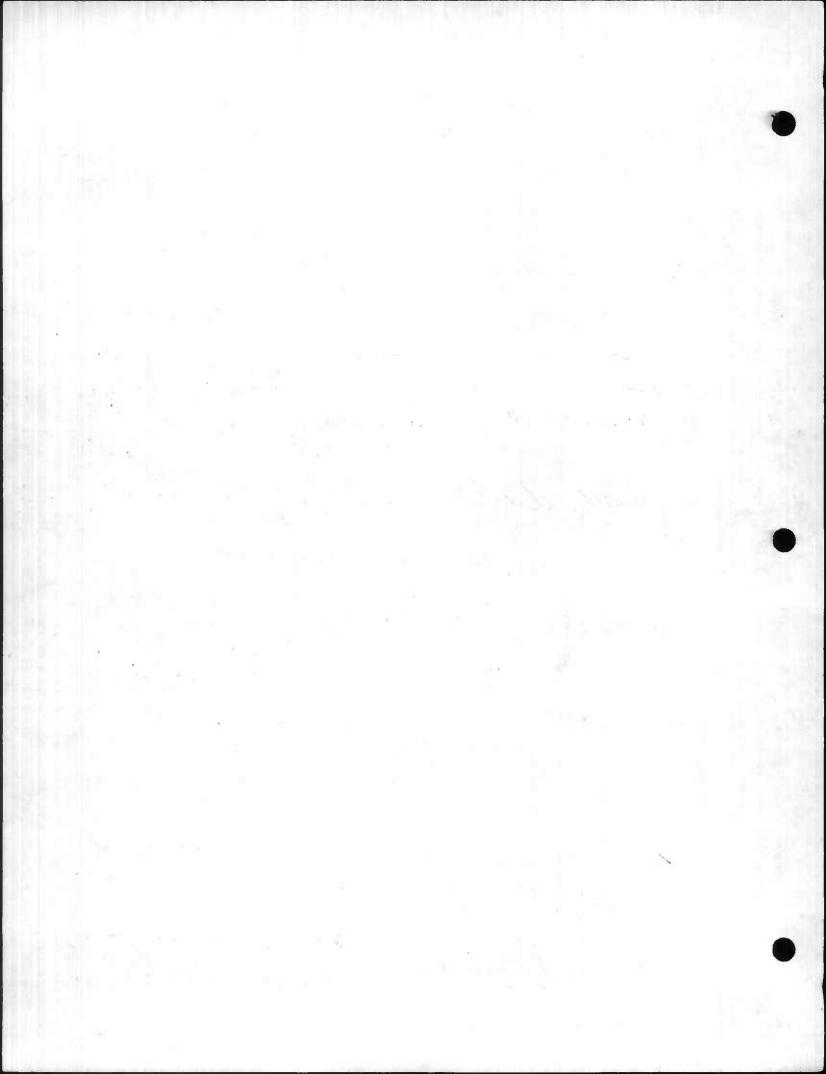
Shivan Gopaul-Gosine, M.D. Kaiser Para

31. Date filed (Month Day Yard) D38521 February 2, 1999 Camp Springs, MD 20748 Karser Permanente 6104 Old Branch Ave. 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State FEB 5 Registrar



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CHARLES S	TANLEY BERCOVITZ	State of M	Maryland		artmen rtificat					giene Reg. No. 9	0	2989
	1. Decedent's Name (First, Middle, L	ast)							2. Date of De		Vana	3. Time of Death
Physician Medical	Charles Stan c	v Bercovi	tz						JAN.	7, 1999	Year	1652 PM
Examiner	4n Facility Name /Mactinethylian a	ve street and number	er)	R		4		wn, or Lo	cation of Death	4c. County	of Death	ORGES
Funeral	5. Social Security Number 6.		Age (In yrs. las	t birthday)	If Under		If Under		8. Date of Birt (Month, Da	th Vene	9. Birth	place (State or Foreign
Director	unknown	10 M 20 F	47	Yrs.	Months	Days	Hours	Min.	Sept 30		Coui	nown
9	Usual Residence of Decedent									2, 2,02		100
ahow and	10s. State 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside City Limits
M Par Oto	Maryland Charle	s	I	Marbu	ry							1 DXYes 2 □ No
or 2	10e. Street and Number				10f. Zip	Code				10g. Citizen of 1	Whet Cour	ntry?
d 21215-0020 Illed within 72 hours after death with the Maryland hygiene. ther than "natural", or items 23a or 28a-f show mit, the Medical Examina must be notified at a Completed by Funeral Director	4215 Creedsmil	l Place				0658				USA		
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than the	20a. Method of Disposition	11, #251	20b. Plac		sition (Nar		y SHE	E TTT	Dete	20c. Location	- City or Tr	own State
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Baltim permit. Pa Departmen important: any injury once.	21. Signature of Tuneral Stories Lion RODALO S	Wade, Dir	ector	S	Name entate	Anat	omy I	Board	d, 655	W. Balt:	imore	Street
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at for the form	1 Natural 5 Pending 2 Accident investigation		2	nlenore	M		Yes 2	No	quests .	unuel a	1 hear	d
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DIVISION OF To the Hoapital or Attanding Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Cartification: 7	29a. Certifier 1 ☐ Certifying P	hysician: To the bes miner: On the basis and manner	of examination			et the tim	e, dete an			cause(s) and m		stated.
Vithin Somple	29b. Signature and title of certifier	101		1	290	c. License				29d. Date signe		
	Denn	of Cher	km			0.0	C.M.E			JAN.	8, 1	.999
34 38	30. Name and address of person who	Chute m	11	1 Pen		reet,	Bal	timo	re, Mar	yland 2	1201	
State Registrar	FEB 0 5 1999	32. Regio	strar's Signatur	. /4	bock	21						



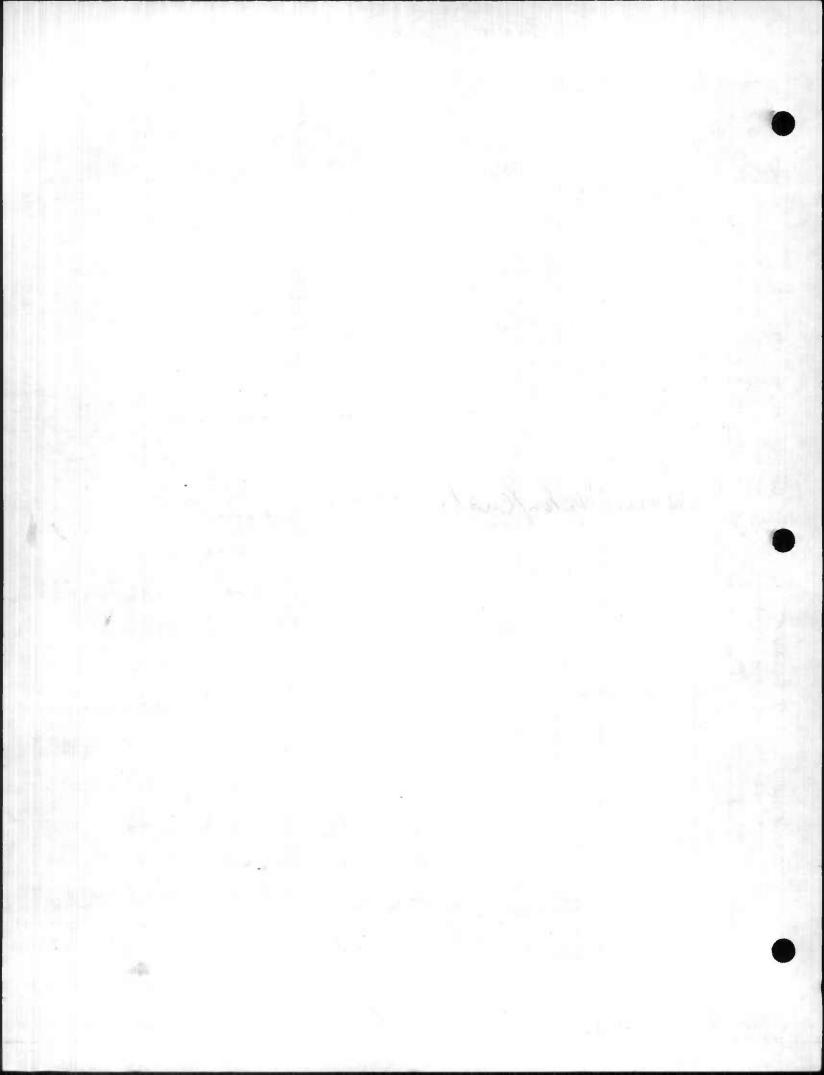
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State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical		FORSTI	ER	BRO		2. Date of De Month JANUA	ry 31,1	Year 999 2:40				
Examiner	4e Facility Name (If not institution, give St Joseph Hospital				4b. City, Town, or TOWSON	Location of Deeth		of Death Cimore				
Funeral Director	5. Social Security Number 6. Se 215–10–9898		yrs. last birthday) Yrs.	If Under 1 Yes Months Dey	ar If Under 24 Hrs			9. Birthplece (State or Country) Mary Land	r Foreign			
Du Bu	Usual Residence of Decedent 10a. State 10b. County	10c	City, Town or Lo	ocation				10d. Inside Cit	ty Limits			
Many and and and and and and and and and and	Maryland Baltimore	To	wson					1 🗆 Yes	No XX			
ath with the Maryle 23e or 28e-f shor unt be notified at rel Director	10e. Street and Number 511 Sussex Road			101. Zip Code 21286			10g. Citizen of V JSA	That Country?				
Ner des	11. Merital Status 1 Never Married 2 Married AXXWidowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No li Yes, Giva Yaar or Dates:		Wes Decedent of If Yes, specify Cu 1□ Yes 200 N	Hispanic Origin? (uban, Mexican, Pue o <i>Specify:</i>	Specify Yes or No rto Rican, etc.)	14. Rece Blec Specify	e - American Indian, k, White, etc. : White				
mary planta ATATO-0000 d2 should be filed within 72 hours at the and Markel Hygiers at The marked other than "restural", or treumsite event, the Medical Exam To Be Completed by F	15. Decedent's Edi (Specify only highest grad Elementery/Secondary (0-12)		16a. Dece (Give life.		upation le during most of wo red)	orking		ery Business				
tal Hyging dighter avent, it	17. Father's Name (First, Middle, Last)		OWITC	31	18. Mothar's Ne	ema (First, Middle,		V				
Mental Mental Mental To B	Henry Brown				Margare	t Leonhard	t					
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mit. Pages 1- partment of He portant: if her y injury or oth	20a. Method of Disposition (C) Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State	•	metory or other p		2/3/99		City or Town, State e. Maryland				
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Physician /Medical Examiner		b	to (or as a consec	quence of):	ery	D'sea	s-e					
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icien: The certificate h rector, page						10	ras 2 No	1 ☐ Yes 2 ☐	No			
the side	25. Was case refarred to medicat examiner? 1	Hospitet: 1 Inpatient 28a. Date of Injury (Month, Day Yea	28b. Tima o	28c. In	Other: 4 Nursing	Home 5 Resident 28d. Describe I						
To the Hospital or Attending P Within 24 hours after death. To the Euneral Director: After it completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, str ecify)			28f. Location (S City or Tox		er or Rural Route Numb	ber,			
Hospi 24 hou Funer etsky fill dical	29a. Certifier Certifying Physical Control (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death ninetion and/or in	n occurred et the vestigation, in my	time, data and plec opinion, death occ	e, and due to the urred et the time,	cause(s) and me deta end pleca, a	nner es stated. and due to the cause(s))			
To the comple comple	29b. Signeture and title of certifler	dooms	5	29c. Lice	053 9	4 7		(Month, Dey, Year)	799			
OKTO.	30. Nama and address of person who co	empleted causa of death (11/	Print) RA	ven Bl	15 7 vd 3rd	FI. BA	altimore 212	139 M)			
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Si	ignature 4	land	,		1					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nema (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth **Physician** ETHET. BOSLEY 7 2,1999 4c. County of Death /Medical February 2 6:25 am 4a. Facility Name (If not institution, giva straet end number) 4b. City, Town, or Location of Deeth Examiner RIVERVIEW CARE CENTER Baltimore BALTIMORE If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6. Data of Birth (Month, Dey, Year) Birthpleca (Stete or Foreign Country) Funeral 1□M 2☑F 85 Yrs Director 215-07-0926 Dec. 14 1913 Balto, Usuel Rasidence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ehov traumatic event, i'm Medical Expreser inust be inclified at Baltimore Baltimore 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21221 U.S.A. 1 Eastern Blvd. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (1)NX if Yes, Giva Yaar or Dates: 11. Marltel Stetus Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, permit. Pages 1 end 2 should be filed within 72 hours efter. Department of Heelth and Mentel Hygiene. I important: If item 27 is merked other than "natural", or lies any Injury or other traumatic event. Black, Whita, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yas X XNo Specify: þ XXX Widowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Own Home Homemaker 3rd 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) John T. Mules Annie Lewis 19e. tnforment's Nems/Ralationship (Type, Print) 19b. Mailing Address (Streat end Number or Rural Route Number, City or Town, Stete, Zip Code) Ellwood E. Bosley, Jr. (Son) 9531 Burton Ave. 21234 Balto, MD 20b. Plece of Disposition (Neme of cemetery, crematory or other plece)

Lorraine Park Cemetery 20e. Method of Disposition Date 20c. Location - City or Town, Stata ₩ Buriei 2 Cremation 3 Removal from Stete Woodlawn, MD 2/4 4 Donetion 5 Other (Specify) 22. Nama and Address of Fecility
Burgee-Henss Funeral Home
3631 Falls Rd. Balto, MB 21. Signature of Funerel Service Licenses 23a. Part1. Enter the disaase, or complicetions that caused the daath. Do not enter the moda of dying, such as cardiec or respiretory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Betwaan Onsat and Deeth Physician Immediate Ceuse (Finel disaese or condition resulting in daath) /Medical **Examiner** Physician/Medical Examiner be executed physician end the buriel-tren Sequentielly list conditions, if any, leading to immadiate cause. Entar Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last P.O. Box 68760, Due to (or as a consequance of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributa to the cause of death? signed by the Waknown 1 Yes 2 No 3 Probably Records, þ 24b. Were autopsy findings aveileble prior to completion of causa of deeth? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only ona) Hospitel: 1 ☐ tnpatient Other: Certification: To 20 No 1 ☐ Yas Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Daeth 1 Naturel 2 Accidant 28b. Time of 28d. Describe how injury occurred 28c. Injury a Work? 5 Panding death. investigation 1 Yes 2 No ofter death 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) in 24 hou.
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Tilled in by 28e. Pleca of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Cartifian Certifying Physician: To tha best of my knowledga, deeth occurred et tha tima, data and place, end due to tha causa(s) and menner as steted. Medical within 24 hor To the Fune completely fi Certarying Physician: To the best of my knowledge, deem occurred at the time, date and piece, and due to the deusets) and menter as stored.

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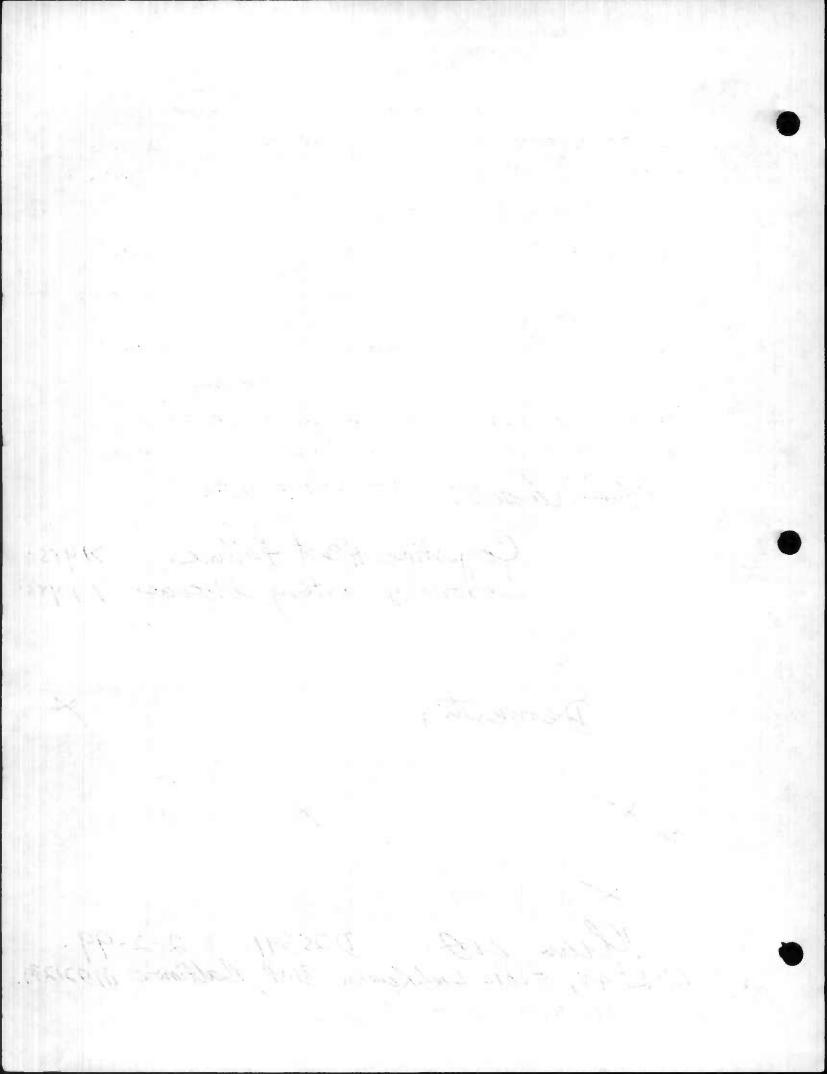
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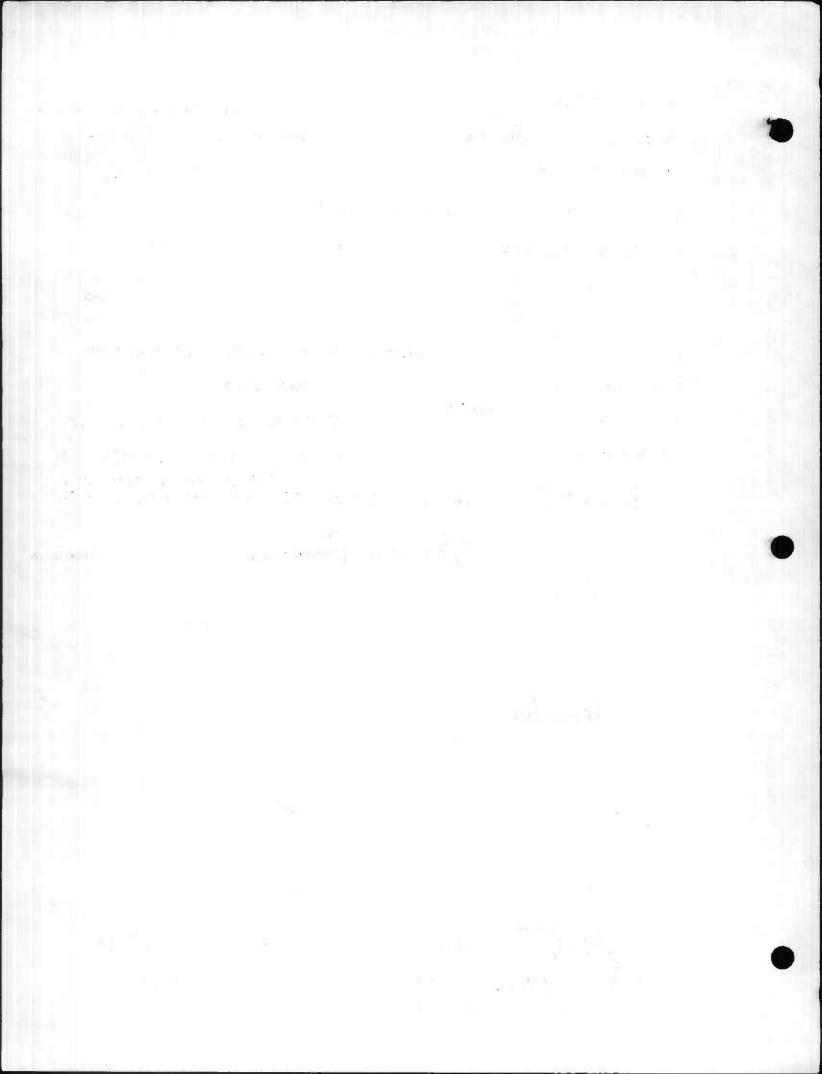
32. Registrar's Signetura

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	Blausialau	Decedent's Name (First, Middle, La	st)		tificate of	Douti	2. Date of Deat Month	h Day	Yeer	3. Time of Deeth
45	Physician /Medical	Robert Carpenter					January	7 28, 19	999	3:45p.m.
	Examiner	4a Facility Nama (If not institution, giv Genesis Commons N				4b. City, Town, or Loc Catonsvi		4c. County of Balt	or Death	e
	Funeral Director	213-14-0023	Sex 7. Age (In y	rrs. lest birthdey) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Aug. 17	Year)		ece (State or Foreign try)
	puel dend	Usual Residence of Decedent 10a. Stata 10b. County	10c.	City, Town or Loc	cation				10	Od. inside City Limits
	e Man	Md. n/a	Ba	altimore						1 As 2 No
3	ufer death with the Maryland r flems 23s or 28s-f show nine must be notified at Funeral Director	10e. Street and Number 1415 King William	Drive		10f. Zip Code 21228		1	0g. Citizen of W USA	hat Coun	try?
	T sta	11. Marital Status 1 Never Married 3 Merried 3 Widowed 4 Divorced	12. Was Decedent Evar in Armed Forcas? 1. ★ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of H Yas, specify Cub ☐ Yes 2 → O	tispanic Origin? (Spe an, Maxican, Puarto t Specify:	cify Yes or No- Rican, atc.)		- America k, White, o	etc.
2	be filed within 72 hours a tal Hygiene. d other than "natural", o event, tre Wedical Exar Be Completed by	15. Decedent's E. (Specify only highest gra	ducation ade completed)	(Give I	ent's Usual Occup kind of work done	duning most of working	ng	16b. Kind of Bu	siness/Ind	lustry
Maryland 21215-0020	jiene.	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)		of Stor	age & Supp	olies (JS Coast	t Gua	rd
ומי	should be filed wit and Mental Hygiene i marked other tha umetic event, tre. To Be Com	17. Father's Name (First, Middle, Last,)			18. Mother's Name	(First, Middle, M			
y	Mer Mer of	Robert Carpenter	To Original To 1 1	405-44-75-	- A Idea - (Charact	Eliza Bis		Cit T	0-1-7-	0-4-1
_	tra d	19e. Informent's Neme/Relationship (Pamela McNeill	<i>Type, Panti</i> daughtei	1415		end Number or Rura Liam Drive				
	T T T T	20e. Method of Disposition	Removal from State		sition (Neme of natory or other pla			20c. Location - (
	Pag ment: H ury o	Burial 2 Cremation 3 Donation 5 Other (Specific				eterans Fe		wings N		
מ	permit. Departr Imports any inj	21. Signature of Funeral Sarvice Licar	nsaa . Trutt			ess of Facility Nutions Falls Pl				
		23a. Part1. Enter the disease, or com shock, or heert feilure. List only	plications that caused tha do one cause on each line.	eath. Do not ente	er the mode of dyl	ng, such as cardiac o	r respiratory arre	est,	1	Approximata Interval Between Onsat and Death
	Physician /Medical Examiner	Immediete Ceuse (Final disaese or condition resulting in deeth)	a	Spirate	in Pa	eumoria				Cukum
	je		Due to	o (or es a conseq	uence of):				1	
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	r requires that the death certific been signed by the attending p should be detached for use as leted by Physician/Me	Demer	ifin	resulting in the di	idenying cause gr	on mranti.			3 Prot	
ecords,	The law requires that the death certificate be assectled at he been signed by the attending physician end page 2 should be detached for use as the burial-transit Completed by Physician/Medical Examir						24e. Was e perform	n autopsy ned?	COL	ore autopsy findings ilable prior to inpletion of cause death?
	Physician: The law this certificate hes ral director, page 2: To Be Comp						1 □ Ye	s 20 No	1 🗆	Yes 2□ No
N I a	r this certificated director,	25. Was case referred to medical examiner?	Hospital:		100	26. Place of Death	(Check only on	Θ)		
	r this of and direction T. To	1 ☐ Yes 2 ☑ No 27. Manger of Deeth	28a. Date of Injury	28b. Time of	1 3□ DOA Ou 28c. Inju Wo	4 Mursing Hor	ne 5 Reside		-	")
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DIVISION	2 0 5 -	3 Suicide 6 Could not b determined	28e. Place of Injury - A building, atc. (Spe	t home, farm, streecify)	et, factory, office	2	28f. Location (St City or Town	reet end Numbe n, Stete)	er or Rure	Route Number,
3	io the Hospital of At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier 1 Certifying Ph	ysician: To the best of my k ninar: On the basis of exam- and manner stated.	knowledge, death Ination and/or inv	occurred at the ti astigation, in my	me, date and place, a ppinion, death occurre	and due to the ca ad at the time, do	ause(s) and me ete and placa, a	nner es st and due to	ated. the ceuse(s)
	within To the comp	29th. Signature and title of certifier		•	29c. Licans	sa number	2	9d. Data signed		
		> /IIINOIUA	W/	7	D.	17564		2/3	179	
	X	///	/			1701				
	OX	30. Name and paragraph of person who	completed cause of death (I	0	print) Steene	The	191	# 300		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Hubert Collins Creasy FEB 1999 0730 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A AGNES ItEALTH CARE BALTIMORE If Under 1 Year | Months | Days | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1√ M 2□ F 216-18-0814 74 APR. 23, 1924 Virginia Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 324 S. Calhoun St. 21223 USA 12. Was Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ KNo white Specify: Specify: 3 □Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Press Operator Foreman Corr. Paper Box 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Creasy Ruth Waldron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Koenig - daughter 30061 Kristwood Way, Princess Anne, Md. 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Cr. 22. Name and Address of Facility 21. Signature of Funetal Septice Licenses Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md. 21075 WUNKS. 233 Part. Enjoy the blades, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final PNEUMONIA WEEK disease or condition resulting in death) Due to (or as a consequenca of): AUCIDENT CEREBROVASUNLAR MEEIL Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initioled events resulting in deeth) Last Due to (or as a consequenca of) PULMONARY EmBolic EVENTS WEEK Due to (or as a consequenca of): MYXOMA D MINTHS TRIAL VENTRULAR Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 20 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. Box 68760. of Vital Records, 日で了

HUBI Division

Medical To the Hosp within 24 hor To the Fune completely fi

Physician

Examiner

Funeral

Director

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Funeral

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r than "naturel", or items 23a or 28a-f short the Medical Examiner must be notified at

permit. Peges 1 end 2 should be filed within 72 hours effer Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or ite, eny Injury or other traumatic event, the Medical Examine.

Physician /Medical

Examiner

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Hospital 24 hours a Examiner

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Certification:

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29a. Certifier

the Maryland

death

Maryland 21215-0020

altimore,

/Medical

29b. Signature and title of cartifier much

RESIDENT

29c. License number

(Secretifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

12 HMSICIAN

P12705

FEB 4, 1999

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) BAAKO SAHC MICHAEL

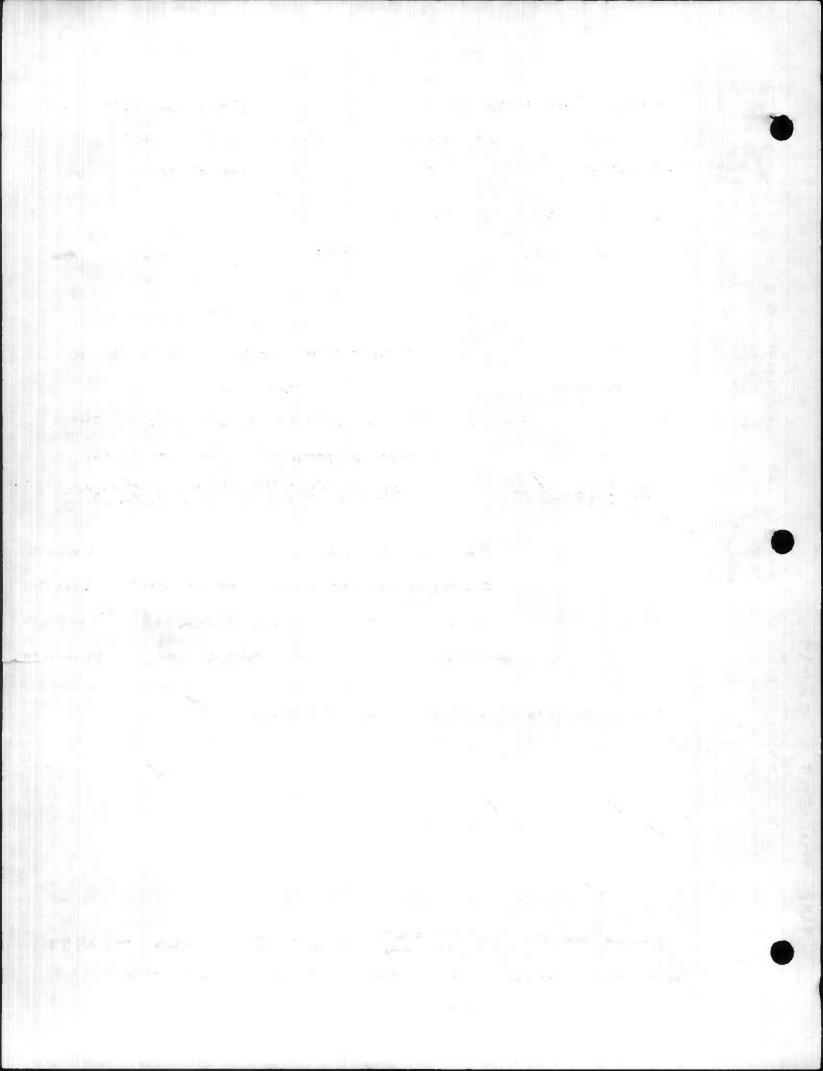
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CATON AVE, BALTO, MD 21229

State Registrar 31. Date filed (Month, Day, Year)

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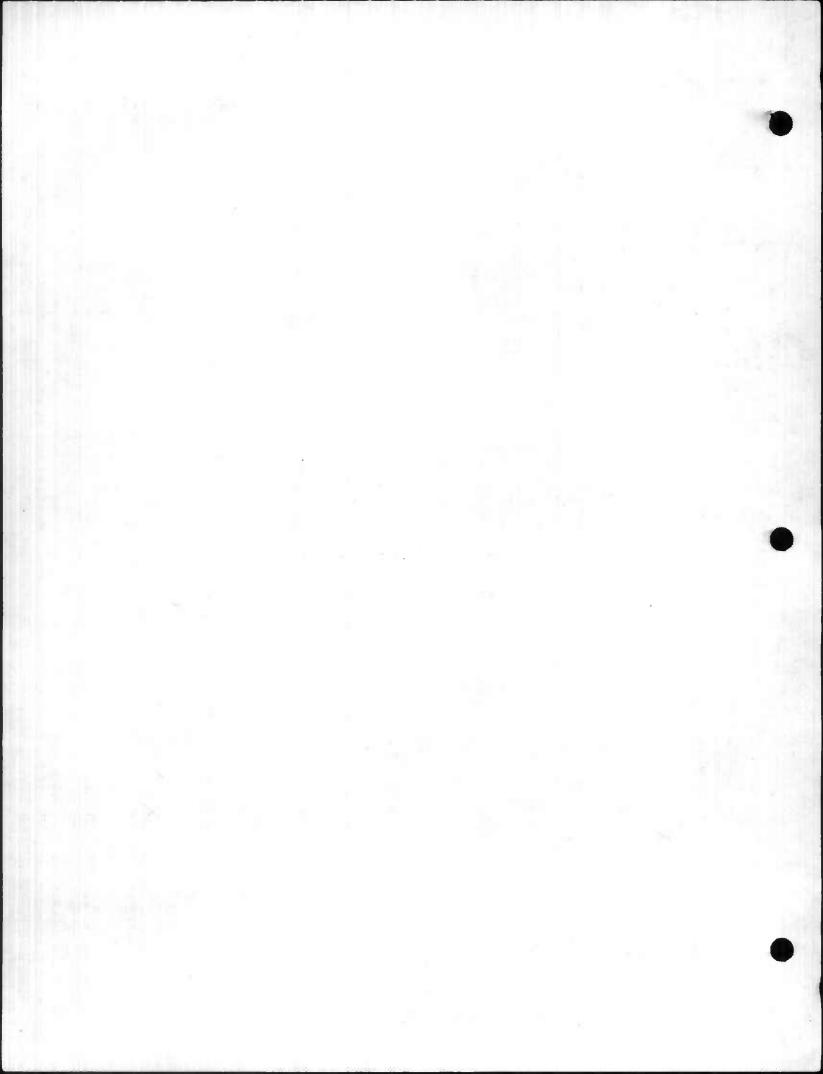
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death	1	Reg. No.	0 6 9 9 7		
0	1. Decedent's Name (First, Middle, La	11.				2. Date of Dea		3. Time of Death		
Physician /Medical	GLENI	CE	Cu	15 TY		Month AEB	3 99			
Examiner	4a Facility Name (If not institution, given	ve street and number)			4b. City, Town, or		4c. County of D	Death		
	1917 E. Prat	t Street			BALTIM		N/A			
Funeral Director	217-18-5831	A THE METERS	yrs. last birthd 74 Yrs	Months Days		8. Date of Birt (Month, Da) SEPT 2	y, Year) 8, 1924	Birthplace (State or Fore Country) Maryland		
ahow stat	Usual Residence of Decedent 10a. State 10b. County		c. City, Town o					10d. Inside City Limi		
1 0 00 00 00 00 00 00 00 00 00 00 00 00	Maryland Ta	1bot			1 0ak					
r term 23s or 28s-1 showing at the modified at Funeral Director	6786 Edge R	oad	11.4		662		10g. Citizen of What US			
ě	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	in U,S.	I3. Was Decedent of If Yes, specify Cu		pecify Yes or No- o Rican, etc.)	14. Race - A Black, W Specify:	wherican Indian, white, etc. White		
natural.	15. Decedent's E	ducation	16a. De	ecedent's Usual Occi	upation	16b. Kind		ess/Industry		
then the month	(Specify only highest gra- Elementary/Secondary (0-12)	College (1-4or 5+)		ive kind of work don e. DO NOT use retir Homemake		xing	Domest	ic		
d other event,	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle,	Maiden Sumame)			
marked other marked other imatic event, To Be Co	Napoleon	LaVoie			May	C. 0'	Connell			
th and Men 7 is marke traumatic	19a. Informant's Name/Relationship ((Type, Print)	19b. M	ailing Address (Stree	at and Number or Ru	ral Route Numbe	or, City or Town, Stat	te, Zip Code)		
0.2	David S. Custy		MD 21231							
or other tr	20a. Method of Disposition 1 Deriai 2 Ocremation 3 D	Removal from State	ob. Placa of Di cemetery,	17 E. Pr sposition (Name of crematory or other pl	ace)	Date	20c. Location - City	or Town, State		
tent	4 Donation 5 Other (Special		Metro C	rematory,		2/4/99	Baltimo	re, MD		
Department of Important: If any Injury or pace.	21. Signature of Funeral Service Lice	of Mc Donald	nald		on Socie		Maryland	Inc. MD 2122		
hysician /Medical xaminer	23a. Part1. Enter the disease, or com shock, or heart fallure. List only immediate Cause (Final disease or condition resulting in death)	a. Res	PIRATE to for as a con	RY F	Aicure	<u> </u>		2 weeks		
la i		CON	ESTIV	E HE	ART P	ARUK	E	1 year		
n and ial-fransit Examinei	Sequentially list conditions,	Due								
physician and is the burial-transit edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. ISCH	Emiz	COR	Diomyo	PATHY		unknow		
Q1 40 -	resulting in death) Last	d.	lo (or as a con	sequence of):						
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rate has been signed by the page 2 should be detached Completed by Physic	Renal Javle	ne - C	1 alm	thon.		24a. Was parfo	an autopsy 24 med?	tb. Were autopsy finding available prior to completion of cause of death?		
	V					101	es 2 No	1 Yes 2 No		
E 0 0	25. Was case referred to medical examiner?	Hospital:		10	ther			son's		
ector Be	examiner? 1 Yes 2 No									
direct direct De B	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yes	r) 280. Fim	ry W						
direct direct De B	27. Manner of Death	n One Place of laive.	At home, farm,	M 1[Yes 2 No	28f. Location (S City or Tou		r Rural Route Number,		
direct direct De B	27. Manner of Death Manner of Death Manner of Death Pending Investigation Investiga	28e. Placa of Injury -	At home, farm, pecify)	M 1[street, factory, office	Yes 2 No	City or Tox	m, State)	r as stated.		
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n 24 hours after death. • Funeral Director: After this centioletaly filled in by the funeral directoral directoral Certification: To B	27. Manner of Death Natural 5 Pending	28e. Placa of Injury - building, etc. (Sp. ayelcian: To the best of my miner: On the basis of examend manner stated.	At home, farm, lecify) knowledge, denination and/or	M 1[street, factory, office seath occurred at the r investigation, in my 29c. Licer	Yes 2 No	, and due to the cred at the time,	m, State) cause(s) and mannedate and place, and 29d. Date signed (M	r as stated. due to the cause(s)		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene: Certificate of Death Reg. No.

					Certificate o	f Death	R	eg. No.	UZ:	990
	Dharaia	1 	1. Decedent's Name (First, Middle, Las	1)	, 111		2. Dete of Deet Month	h	'eer 3.	Tima of Deeth
	Physic /Medi		NORMAN A	1. CYNEC			FEB		998	1:15 AM
	Exami		4e. Fecility Name (If not institution, give	street end number)		4b. City, Town, or Lo		4c. County of	Death	
		. 13	STELLA MARI		E	TIMONI	4M	BA	LTIN	ICRE
	Funeral		5. Sociel Security Number 6. So	7. Aga (In yrs. Ia	Months Dev	ar If Under 24 Hrs.	8. Date of Birth (Month, Dev.	Year) 9	Birthplece Country),	(Stete or Foreign
	Director		214-08-61134	90	Yrs.		NOV. 30	1908	Md	
	and *-		Usuel Residence of Decedent 10a. Stete 10b. County	10c. City.	Town or Location				10d I	insida City Limits
	Varyi 1 sho	ō	Md BALTI		PARKUIII.	e Wal				I □ Yes 2 ▼No
	28 th	Director	10e. Street end Number	MORE	10f. Zip Code			0g. Citizen of Wha	at Country?	
	With the same	ā	/ //	REPORD ROAD		234		1111111		
	be filed within 72 hours after death with the Maryland ital Hygiane. d other than "natural", or frems 23a or 28a-f show event, the Madical Example must be notified at	Funeral	7606 Old HA 11. Marital Status	12. Wes Decedent Evar in U.S.			ecify Yes or No-	14. Race -	American Ir	ndien.
0	r ther	Ē	1 Nevar Married 2 Married	Armed Forces? 1 ☐ Yas 2. No		Hispanic Origin? (Spe iben, Mexican, Puarto	Rican, atc.)		White, etc.	1
21215-0020	72 hours af natural', or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Detes:	1□ Yas 2⊠N	o Specify:		Specify:	WHI	/ =
0	natur	ted	15. Decedent's Ed	ucation	16a. Decedent's Usuel Occ	upation		16b. Kind of Busin	ness/Industr	у
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	od withi	5	10 Th	NA	BAKE	e		BAKE	RY	
nd	be filed tal Hyg d other	Be	17. Fether's Neme (First, Middle, Last)			18. Mother's Neme				
<u> </u>	Men	P	Joseph L. C	UNEO		LILIA	U HEL	FER		
Maryland	d 2 should be filed within the and Mental Hygiane. 7 le marked other than traumatic event, the H		19e. Informent's Neme/Reletionship (7		19b. Melling Address (Stre					
بة الح	and leelth m 27		CLARA & CUNE		7606 Old A					
יסוסו	t of H		20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐	Removel from Stata	ca of Disposition (Neme of netery, cremetory or other p	lece)	1-1	20c. Location - Cl		
H	Pa man man ury		4 ☐ Donation 5 ☐ Other (Specify	PAI	RKWOOD CE		13/99	BALTO	Col	ud.
Baltimor	permit. Pages 1 and 2 should be filed with Department of Heelth and Mental Hygiene, important: if fem 27 is marked other than any Injury or other traumatic event, the Mones.		21. Signeture of Funerel Sarvice Licans	9	22. Nema and Add	ress of Facility // E	RFUN	eral H	OME,	CHTO
y m	40 E 6 0		Cotter M	alle.	7527 1	IMPFORD	Rd. B	AltoN	ld z	1234
			23a. Part1 Extenthe disease or companion; or heart failure. List only of	dications thet caused the deeth.	Do not enter the mode of d	ying, such as cardiac of	or respiratory erre	est,	Apr	oroximete arvel Between
	Physician								One	sef and Deeth
7	/Medical Examiner		Immediate Ceuse (Finel disaese or condition resulting in death)	. End Stage	Congestive	Heart F	ailure		i	
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0	ding Ph h. After th funeral		27. Menner of Death 1 □ Naturel 5 □ Pending	28a. Dete of Injury (Month, Dey Year)	8b. Time of 28c. in W	ury et ork?	28d. Describe ho	w Injury occurred		proc
Sio	aath. or: A	cati	2 Accident Investigation		M 11	Yes 2 No				
Division of	frar d fract	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At hom building, etc. (Specify)	e, farm, street, factory, offic	a	28f. Location (St. City or Town	reet end Number , Stele)	or Rural Ro	ute Number,
	urs a		00-0-17						-	
	To the Hospital or Attanding Physician: within 24 hours aftar death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29e. Certifier 1 Certifying Phy cone) 1 Medical Exam	sician: To the best of my knowle inar: On the basis of exeminetio end manner stated.	edge, deeth occurred et the n end/or investigetion, in my	time, dete end plece, a opinion, death occurr	and due to the ca ed et the time, da	luse(s) end mann ate end plece, end	er as steted d due to the	ceuse(s)
	ithin o the	M	29b. Signature and fibe of certifier	end manner stated.	29c. Lice	nse number	2	9d. Data signed (/	Month, Day,	Year)
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	eg!)		30. Neme end address of person who c	ompleted cause of death //		11105		5/0	(()	
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	Sta	ate	Dr. Tariq Mal 31. Dete filed (Month, Day, Yeer)	32. Registrer Signetur	ouraney val		, Timo	ulum,_M	בט 17	093
	Registr		FEB	1999	P. 19	oacks!				

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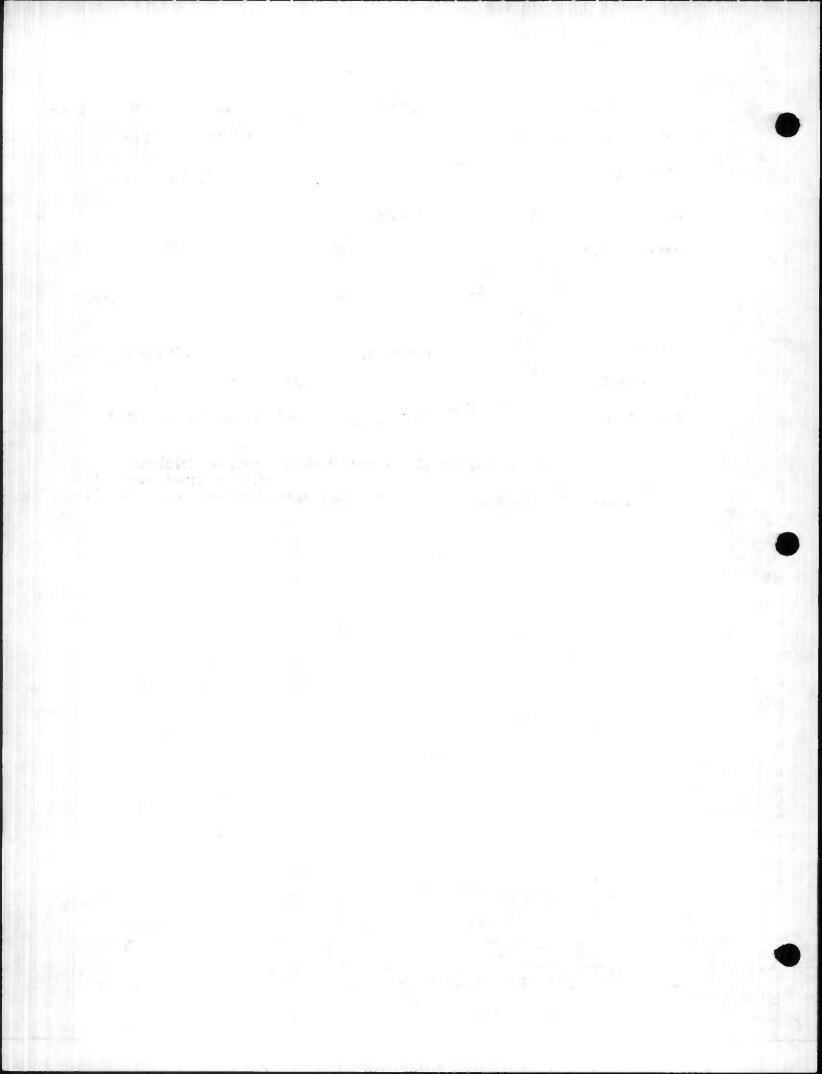


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State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decadent's Nama (First Middle Last) 2. Deta of Daath 3. Tima of Deeth **Physiclan** Davis Month Sarah Feb 03/5 /Medical 4a. Facility Nema (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Augsburg Lutheran Home Pikesville Baltimore if Under 1 Yeer if Undar 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Yaar) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpiace (Stata or Foraign Country) **Funeral** Days Months Hours 1 M 250R 90 218-28-8758 Vrs Director May 4, 1908 NC Usuat Residence of Dacadeni with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. tnsida City Limits 28a-f show Herra 23a or 28a-f show Baltimore Pikesville 1 Yas 2 XXIO Directo 10e. Straat and Number 10f. Zip Code 10g. Citizan of What Country? 7317 Campfield Road 21208 USA Funeral filed within 72 hours after death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Dates: Was Dacedant of Hispanic Origin? (Spacify Yes or No-tf Yes, specify Cuben, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, The Medical Examiner Black, Whita, etc. 1 Navar Married 2 Married 21215-0020 ŏ 1 Yas 2 No Completed by 3√Widowed 4 □ Divorced Specify: Black "natural", 15. Decedant's Education 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry (Spacify only highast grade complated) el Hygiane. Eiamentary/Secondery (0-12) Coliega (1-4or 5+) 6th Grade Homemaker Private Families traumatic event, Baltimore, Maryland permit. Peges 1 and 2 should be file Department of Hasth and Mentel Hy Important: If Itam 27 Is marked othe any injury or other traumatic event, once. 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Henry Ward Sarah DeShields 19a. Informant's Neme/Retetionship (Type, Print)daughter 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Sarah Epperson 7317 Campfield Road Pikesville, Md. 21208 20b. Piace of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriat 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 Donation 5 Rother (Specify) Entombment Arbutus Memorial Park Feb. 6 Baltimore, Md. 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeret Sarvice Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 treviso hutter 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Onsat and Death Physician /Medical Immadiata Causa (Finat ASCUD disaase or condition rasulting in daath) ravs Examiner Due to (or es e consequance of) Examiner The law requires that the death certificete be assecuted buriel-transit Sequentially list conditions, if any, taading to immadiate cause. Entar Underlying Causa (Disaasa or injury that initiated events resulting in daath) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the burie Physician/Medical the Dua to (or as a consequence of): Part tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dtd tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown recent MEUMONIA ģ Completed 24b. Were autopsy findings evellebta prior to completion of ceuse of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yas ANO 1 ☐ Yes 2 ☐ No spital or Attending Physician: Theory safer death.

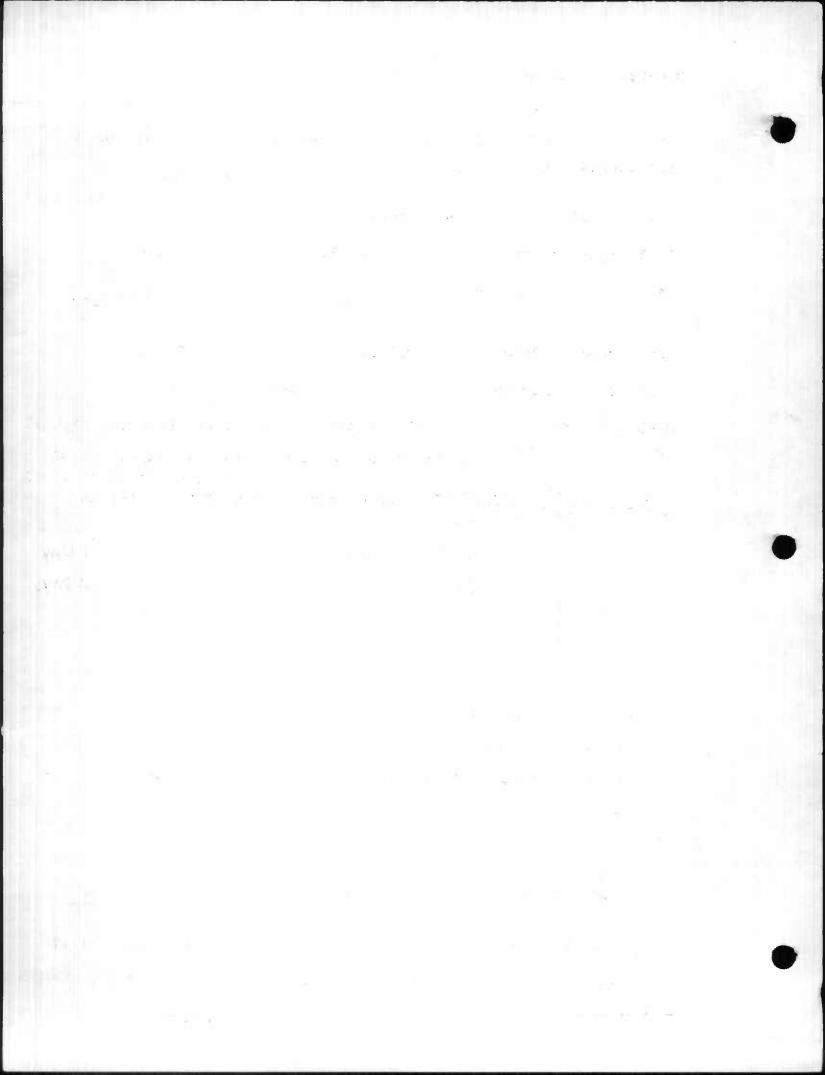
neral Director: After this certificate y filled in by the funeral director, pa Be 25. Was casa rafarred to medicei 26. Piece of Daath (Check only ona) Other: The Nursing Home 5 Residence 6 Other (Specify) P 1 Yas 2€No 1 tnpatiant 2 ER/Outpetiant 3 DOA 27. Mannar of Death 28a. Data of injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Waturai 1 Yes 2 No 2 Accident 3 Suicide 6 Coutd not be datarmined 28a. Ptace of tnjury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 - Homicida To the Hospital or within 24 hours at To the Funeral D completely filled i 29a. Certifian 12 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. Medical 29b. Signetura and titia of certifian 29c. Licansa number 29d. Dete signed (Month, Day, Year) 037573 30. Nama and address of person with go complated ceusa of daath (ttam 23a) (Type, Print) Baltone Ave MD 80715 Tibell 7220 Park MV 32. Registrar's Signature 31. Data filed (Month, Day, Year) State FEB n 5 1999 Registrar

DHMH 16 Bay 6/95



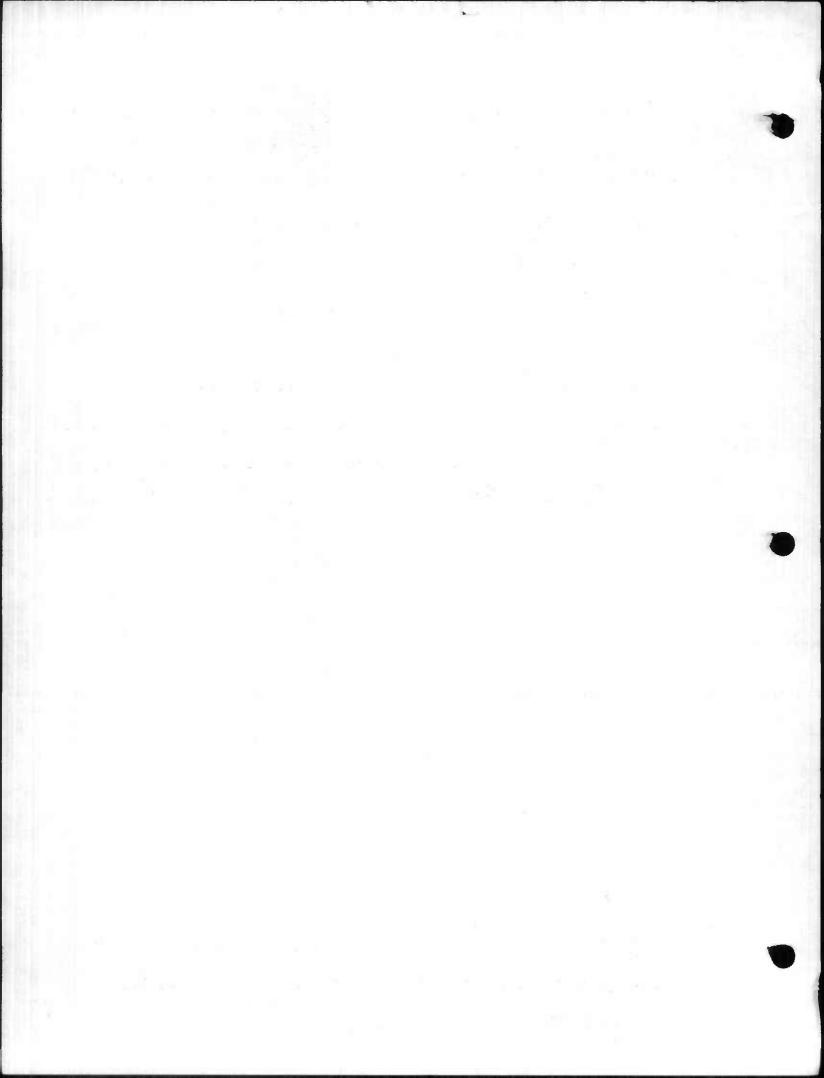
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	Item:31 per V.R 2/5/99	reb		ate of Death		Reg. No.	02931
Physician	1. Decedent's Name (First, Middle, Las	at)			2. Data of D Month	Day th	3. Time of Death
/Medical	REUBIN PAU			44 600 7	FEBRU	ARY 5	1111
Examiner	4a Facility Name (If not institution, give HARBOR HOSP		ER	BALTI	Town, or Location of Dea YORE		TIMORE
Funeral Director	5. Social Security Number 187-40-0863 8. Security Number 187-40-0863	7. Aga (In yrs	. last birthday) If Un Mont		Min. 8. Data of E (Month, I	Sirth (Day, Year) 28-53	Birthplaca (State or Foreign Country) PA
P &	Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Location				10d. inside City Limits
Aanyla F sho	MD NA		altimore				1 No Yas 2 No
the N	10e, Street and Number			Zip Code		10g. Citizen of V	What Country?
3a or	1213 Light Str	eet	2	1230		USA	
s 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. If Health and Mental Hygiene, and To Be count, the Health and Instituted to their traumatic event, the Health Exercites in the rectified at other traumatic event, the Health Exercites in the rectified at To Be Completed by Funeral Director	11. Marital Status 1 🔀 Navar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yas 2 No If Yes, Give Year or Dates:		cedant of Hispanic C pecify Cuban, Mexico No Specify	origin? (Specify Yes or Nan, Puerto Rican, atc.)	No- 14. Rac Blac Specify	e - American Indian, ck, White, etc.
2 hou	15. Decedent's Ed	ucation	16a. Decedent's L	sual Occupation	ant of considers	16b. Kind of Bu	usiness/Industry
and Mental Hygiene. sumaric event, the Medical a	(Specify only highest grade) Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)	life. DO NO	work done during mo Tuse retired)	ost of working	Churc	h
d other	17. Father's Name (First, Middle, Last)			18. Mot	her's Name (First, Midd	lle, Meiden Sumem	ne)
Menta rked etic e	Albert A	lston			atherine	Dow	
is marker reumatic To	19a. tnforment's Name/Relationship (7	Type, Print)	19b. Mailing Addr	ess (Street end Num	ber or Rural Route Num	ber, City or Town,	Stete, Zip Code)
	Rosalyn Dov 20a. Method of Disposition 1 Burial 2 Cramation 3 C	20b. Ramoval from Stata	Place of Disposition (cemetery, crematory	Neme of or other place)	nue Apt.#	20c. Location -	klyn,NY 112] City or Town, State timore,MD
Department Important: It any Injury o	4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen		New Cathe	and Addrass of Fac			
Depa Impo	21. Signature of Purietal Service Licen					ore, Ma .North .	ryland 21202
	23 art1. Enter the disease, or comp	plications that caused the dea		.March I			Approximate
ysician Medicai caminer	23. anti. Enter the disease, or comp shock, or heart failure. List only of trimediate Ceuse (Final disease or condition resulting in deeth)	е. Нур	OTENSIO	N			inferval Between Onset and Daath
			or as a consequence	of):			2 DAYS
in and hal-transit Examiner	Sequentielly list conditions	b	(or as a consequence	of):			
ian ar urial-t	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
ettending physician and for use es tha bunial-transit clan/Medical Examir	that initiated events rasulting in death) Last	Dua to	or as a consequenca	of):			
of for	Part il. Other significant conditions co	ontributing to death but not re	esulting in the underlying	o cause given in Per	t i. 23b. Di	d tobacco use co	ntribute to the cause of death?
igned by the ettending be detached for use by Physician/M	PAN HY PO PITU						3 ☐ Probably 4 ☑ € Onknown
been s should	DIABETES	MELLITU	S		24a. Wi	as an autopsy rformed?	24b. Were autopsy findings availabla prior to completion of cause of death?
page 2	KLINEFELT	ERS SYN	DROME		10	Yes 2 10 No	1 ☐ Yes 2 ☑ No
rector, pag	25. Wes case referred to medical examiner?			26. Pla	ce of Death (Check onl	y one)	
To	1 □ Yes 2 □ No	Hospitel: 1 Inhpatient 2	ER/Outpetient 3		Nursing Home 5 Re	sidence 8 D0th	ner (Specify)
or deeth. octor: After this certific: by the funeral director, iffication: To Be (27. Menner of Deeth 1 Naturai 5 Pending 2 Accident investigation	28a. Date of injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work?		e how injury occur	red
# 5 E	3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of injury - At building, etc. (Spec		tory, office	28f. Location City or 1	(Street and Numb Town, State)	ber or Rural Route Number,
within 24 hours to the Funeral completaly filled		ysictan: To the best of my kr iner: On the bests of examir and manner stated.					
withir comp	29b. Signature and titla of certifier	ni I		29c. License numbe			d (Month, Day, Year)
	Archane F. S			RES 000)	FEBRUAR	ky 5 th 1999
	30. Name and address of person who of ARCHANA K SH	TYAMSUNDEK,	3001 South H	ANOVER	STREET, BA	LTIMORE	HARYLAND 21225
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 1000	Roman	6	Married World Street	



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				Otate of Ivi	arylaria /		ificate of	Death		Reg. No.	UZ	998
т	Dhysiai	an	1. Decedant's Nama (First, Middla, Last,						2. Date of Dea	ith Day	Yaar	3. Time of Death
	Physici /Media		Harrand	Flowe	rs				Feb	OI	99	5;53pm
	Examir		4e. Facility Neme (If not Institution, give					4b. City, Town, or I	ocation of Deeth	4c. County	of Deeth	
			Union Memor	ial Ho	50			Baltim	ore	N	/ A	
	Funeral		5. Sociel Sacurity Number 6. Ser		e (In yrs. last	birthdey)	If Under 1 Year	If Under 24 Hrs.				eca (Stata or Foreign
	Director		109-03-0357	M 2□F	92	Yrs.	Months Days	Hours Min.	8. Dete of Birth Month, Day DEC 27	, 1906	Mich	higan
	show		10a. Stata 10b. County		10c. City, To	own or Loca	tion				10	d. inside City Limits
	death with the Maryland ms 23a or 28a-f show I must be notified at	to	Maryland N	/ A			Balti	lmore				ty Yas 2□No
	1 the	20	10e. Street end Number				10f. Zlp Coda			10g. Citizen of V	What Count	rv?
	23a or		217 Chancery	Road			2121	Ω			USA	•
	Joeth Tre 2	era		12. Was Decedent	Ever In U,S.	13. Wa			pecify Yas or No-	14. Rec	e - America	ın Indian,
21215-0020	or ite	by Funeral Director	1 ☐ Nevar Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forcas? 1 XYas 2 ☐ If Yes, Give Yaar or Detes:			es, specify Cut Yas 2⊠ No	Hispanic Origin? (S pan, Maxican, Puart Specify:	o Rican, atc.)	Specify Specify	ok, White, a	
ö	"netural".	8	15. Decedent's Edu	eation			nt's Usuei Occu	nation		16b. Kind of Bi	isinass/Indi	ustry
15	in 72	Completed	(Specify only highast grade	completed)		(Give kir iife. DC	nd of work done NOT use retire	during most of wor	king	100.11.11.001.01	30110001110	2007
212	a withir jane. r than	E	Elementery/Secondary (0-12)	Coilega (1-4or 5	5+)	Teac		·		Educa	tion	
	2 should be filed within and Mental Hygiane. Is marked other than reumatic event, the Mental County to the Mental	BeC	17. Fathar's Nama (First, Middia, Last)	•				18. Mothar's Nan	na (First, Middle,			
Maryland	ental ental cev	To B	Norman Flower	`S				Mabe	1 Farra	bne		
7	mari	-	19a. informant's Name/Raiationship (Ty		1	9b Maliing	Addrass (Stree	t and Number or Ru			Stata Zin I	Code)
X	d 2 stranger		Margaret C. Flo	•		_		ry Road		imore,		
ē,	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 is marked othe or other traumatic event,		20a. Method of Disposition	WCI 5/ WI	20b. Place	of Disposit	ion (Name of		Deta	20c. Location -		
altimore,	ages nt of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	amoval from Stata	ceme	etery, crema	tory or other pie		20 /01 /00			
	it. P		4 Donation 5 Other (Specify)		Metr			y, Inc.	32/04/99	Balti	more,	, MD
Sa B	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funerel Sarvice License	undis		Cr	Nama and Addr ematio	n Socie	tv of N	D. In	с.	
	40240		Edward A. Ere	The second secon		29	9 Fred	erick R	oad Ba	altimo:	re, N	4D 21228
			23a. Part1. Entar the disaesa, or compil shock, or haert failura. List only or	cations thet caused e cause on aach lie	the deeth. D	o not entar	tha mode of dy	ing, such as cardied	or raspiratory ar	rest,		Approximata intarvai Between
3	Physician											Onset and Death
7	/Medical		Immediata Causa (Finai disease or condition	Myara	rdial	In	farct	ion			0	ninutes
п	Examiner		resulting in death)		Dua to (or as							
	D #	Examiner		Coron	oni	Arter	TI Di	Slase				Jones
	ocute nd trans	E	Sequentially list conditions,		Dua to (or as			2000				Jear 5
Ö	e axe		Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disesse or injury that initiated events								į	
68760,	ificate be axecuted g physician and as the bural-transit	edicai	that initiated events rasulting in deeth) Lest		Dua to (or as	a conseque	nce of):					
_	ng pt	-									1	
Box	death cert e attendin ed for use	an									1	
	death ed fo	SCI	Part ii. Other eignificant conditions con	tributing to death be	ut not rasulting	g in tha und	arlying causa g	ivan in Part i.	23b. Did t	obacco uee co	ntribute to	the cause of death?
P.O.	t the	Ph.	0.1.						101	res 2□ No	3 ☐ Prob	ably 4⊠Unknown
	es that tha death certific igned by the attending p be detached for use as	by Physician/M	Cardiomyopat	ny								
Records,	- 0 T	8							24a. Wes	an autopsy med?	24b. War	re eutopsy findings Ilabia prior to
S		Completed							perior	medi	com	pletion of cause
	The la	E							1 U Y	as 2 No	10	Yes 2□ No
ta	n: T		25. Was casa rafarred to medicai					OC Diseased Day		000	'0	165 20 140
of Vital	Physician: The law this cartificate has be ral director, page 2 s	o Be	examiner?	ospitel:	- ONED	Outpatient	- OI	hor	ith (Check only o		40 "	
o	a this	2	27. Manear of Death	28a. Deta of Injur		b. Tima of	JU DON	4 Li Rursing n	oma 5 Rasid			,
On	Afte fund	후	1 Natural 5 Panding investigation	(Month, Day	y Year)	Injury	28c. Inju Wo	ork?]Yas 2 □ No				
Division	or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Sulcida 6 ☐ Could not be	28a. Placa of inju	ury - At home	farm stree			281. Location (S	treet and Numb	er or Rurai	Route Number
S	or after Direction	Ta	4 ☐ Homicida datermined	bullding, ato	. (Specify)	, 14,111, 01,00	t, rectory, cimos		City or Tow	n, Steta)	0	710010 770111001,
	pottal ours orai		29e. Certifilar 17 Certifying Phys	icien. To the best s	of mus knowled	las doeth s	sourced at the t	less date and since	and due to the			
	To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funeral	Medical	29e. Certifiar (Check only one) CertifyIng Physical Examination	er: On the basis of and mennar sta	axamination	and/or inves	stigetion, in my	opinion, deeth occu	rred at tha tima, o	ause(s) and ma lata and placa,	and due to	tha cause(s)
	ithin o the	Me	29b, Signature and title of certifier				29c. Licen	se number		29d. Data signe	d (Month. D	Pav. Year)
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		4	100					100	ľ	7,0,0	1	
-			30. Nama and address of person who co		aath (itam 23	a) (Type, Pr	int)	0	0	110 0	10.0	
			31. Data filed (Month, Day, Year)		3 1 Ox	- Un	iversity	PKWY	Dalto	MDQ	19/18	
	Sta Registr		FEB n 5 1999	32. Hegistre	ar's Signetura	4	,					
	negisti	al I	LLR II 2 Iddd	444		44	-					



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Hilda February 2105 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Medical System | DaiTimore

7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Baltimore University Mary land ot 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 577-46-6725 Director Oct. 29, 1933 Maryland Maryland Usual Residence of Decedent the Marylan r 28a-f show a notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel **Gambrills** 1 Yes 2 No Directo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 1070 Springhill Court 21054 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 72 hours after 1 Never Marned 2 Merried Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygians. Important: If tem 27 is marked other than "n any injury or other traumatic event the Man Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis DeSales Ogle Maude Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Lawrence J. Fay - Husband 1070 Springhill Court, Gambrills, MD 21054 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Slete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Lakemont Cemetery 2/6/99 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licer 22. Name and Address of Facility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 5 days neurologic Examiner Due to (or as a consequence of): Examiner atheroscleratic discar the attending physician and hed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown insufficiency commany Division of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? disease 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 5 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: a or Attending F a ther death. I Director: After After 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide To the Hospital or within 24 hours at To the Funeral D completely filled I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

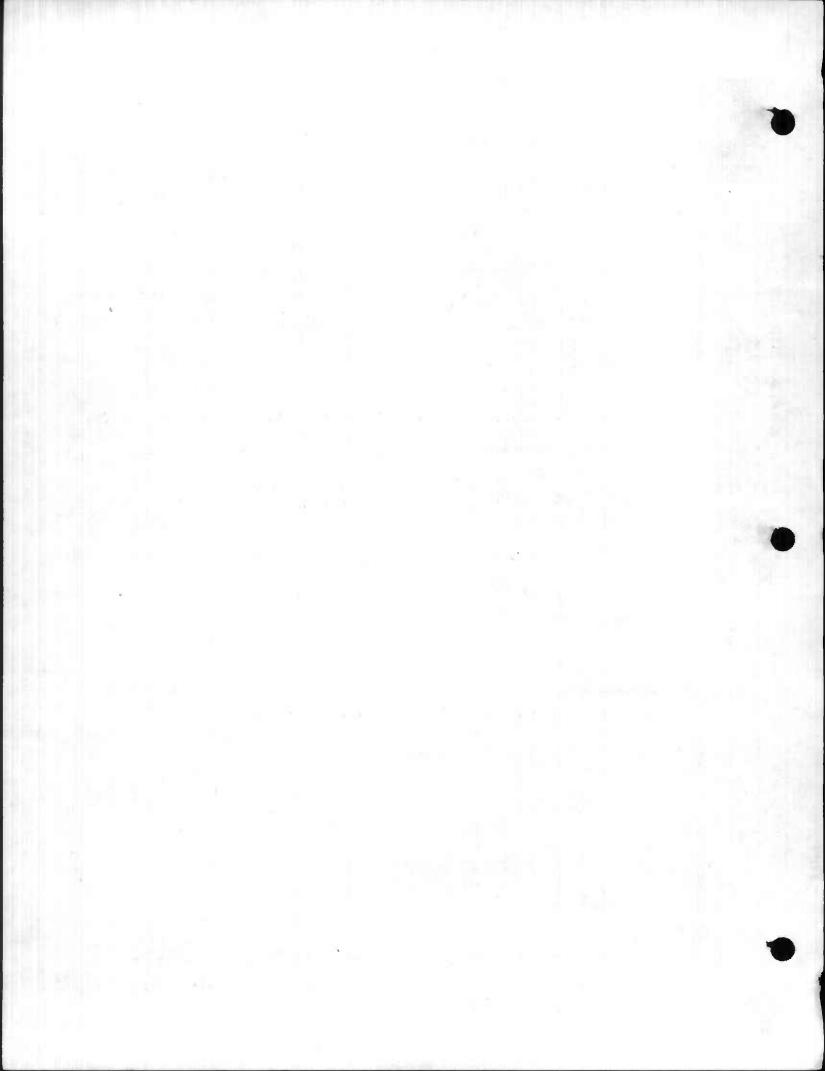
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) momo 3,1999 D0050589 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0. CynThia Nelmi mi umma S. Greene Baltmor, MD 31. Date filed (Month, Day, Year) 32. Flog State

DHMH 16 Rev 6/95

Registrar

5 1999

FEB



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State of Maryland / Department of Health and Mental Hygiene 9 0 3 0 0

				Certin	ficate of	Death	R	eg. No.		
Physician /Medical	1. Decedent's Name (First, Middla	E. Gra	The state of the s	,			2. Date of Deat Month	31 C	79	3. Tima of Death 7: 06 p
Examiner	4a. Facility Nama (If not institution,		r)				r Location of Death	4c. County of		
Funeral Director	Longview Nurs: 5. Social Sacurity Number 216-74-2934		ige (In yrs. le		Under 1 Year ionths Days		s. 8. Data of Birth (Month, Day,	Year)	9. Birthpla Country	County ice (State or Foreign y)
	Usual Residence of Decedent						JULY 30,	1918	Mary	land
how	10a. State 10b. County			, Town or Locati					100	d. Inside City Limits
or 28a-f s be notified Director	MD Howard		E11:	icott C	ity					1 ☐ Yes 2 ☐ No
ms 23a or 28a-f show Livust be notified at	10e. Street and Number 4813 South Has	ven Drive			10f. Zip Code 2104	3	1	0g. Citizen of WI USA		y?
it, or its	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces d 1 Yes 2 If Yes, Give Yaar or Dates] No		Decedent of I is, specify Cub Yes 2X No		Specify Yes or No- rto Rican, atc.)	14. Race Black	- Americar , White, et whit	c.
natur edical	15. Decedent' (Specify only highest Elemantary/Secondary (0-12)	Education grade completad) College (1-4or	5+)	16a. Decedent (Give kind life. DO	's Usuai Occup d of work done NOT use retire	pation during most of we	orking	16b. Kind of Bus	siness/Indu	stry
Hygiene. ont, the Mo	0			Never	Worke	d		Neve:	Never Worked	
Be Man	17. Father's Name (First, Middle, L	ast)				18. Mother's Na	ame (First, Middle, M	<i>leiden Sum</i> ame)	
Mental write ev wife ev							e G. Arsc			
2 4 2	19a. Informent's Name/Reletionsh						Rural Route Number		State, Zip C	iode)
or other traumatic	Lillian G. Mue 20a Method of Disposition 1 Description	len Burnie 02/04/99	20c Location - City or Town State							
Department of important: If any injury or otice.	4 □ Donation 5 □ Other (50) 21. Signature of Fundal Service L	1	Loud	don Park	ama and Addre	es of Facility			o., M	
Depart Import any inj stice	· Sull	1/		- Gary 7250	L. Ka Washi	ufman Fu ngton Bl	neral Hom vd., Elkr	e @ Mead idge, M	owrid d. 2	ge MP, I 1075
hysician	23a, Part 1. Enter the Green in Co. shock, or heard failure. List o	that cause nly on cause on each	id the death.	Do not antar th					i ir	Approximate ntarval Between Onset and Death
/Medical examiner	Immediate Cause (Final disaase or condition resulting in death)	a	Due to (or	ment:	ice of):	koy A	It Lewis	type		102
an and rial-transit	Sequentially list conditions	b	Due to (or	as a consequen	ce of):					
physician and s the burial-transit edical Examir	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	C. —								
Z e e	resulting in death) Last	d	Due to (or a	as a consequen	ce or):					
d for use	Part II Other elgolificant condition	a contributing to doub	but not rooul	tion in the conde	tulo o ocupo ot	una in Dant I	nob Bid to			
igned by the attand be detached for us by Physicland	Part II. Other eignificant condition	contributing to death	out not resul	ting in the under	Tying cause gi	/an in Part I.	236. Did to			he cause of death bly 4 Unknow
cate has been signate begins and page 2 should be Completed b							24a. Was ar perform	n autopsy ned?	availe	e autopsy findings abla prior to pletion of cause ath?
							1 □ Ya	s 2 No	101	Yes 20 No
s certificate director, par To Be Co	25. Was casa referred to medical axaminer?	Administration of the second o			100		eath (Check only on	3)		
유민	1 Yes 2 No 27. Manner of Beath	Hospital: 1 Inpati		-	DOA Oth	4 Mursing	Home 5 ☐ Reside			
octor: After by the funer ification:	1 Neturel 5 ☐ Pending 2 ☐ Accident investiga		ay Yaar)	28b. Time of Injury	28c. Injui Wor M 1 □	yat rk? Yes 2 □ No	28d. Describe how injury occurred 2 □ No			
원등 보	3 Sulcida 8 Could no determin	ed 289. Place of in	jury - At horr tc. (Specify)	ne, farm, street,	factory, office		28f. Location (Str City or Town	reet and Number , Stete)	ro <i>r Rural F</i>	łoute Number,
within 24 hours is To the Funeral I completely filled	29a. Certifier (Check only one) 2 Madical Ex	Physician: To the best aminar: On the basis of and manner st	of examinatio	edge, deeth occ on and/or investi	curred at the tir gation, In my o	ne, date and plec pinion, death occ	a, and due to the ca urred at the time, da	use(s) and meni ite and placa, an	ner es state id due to th	ed. ne cause(s)
within To the comple	29b. Signature and little of contifier	hn		<	29c Licens	e number	29	d. Date signed	(Month, Da	y, Year)
9/	30. Name and address of person wi	no completed cause of	deth (Item 2	23a) (Type, Print		1) 5165		4	149	
V	ZIII Hanorex	Pha 1	any	Heal	mg	2102	4			
State Registrar	31. Date filed (Month, Day, Year) FFR 5 19	99 32. Aegisti	rar's Signaty	re G	1	127				

